Page 4 of 6 received at 1122/2008 11:28:49 AM [Eastern Standard Time] on server AS-BWTRFAXSVR06.

Authorization	Proposed Insured: The Metropolitan Life Insurance Company MetLife Invest New England Life Insurance Company General Ameri MetLife Investors Insurance Company Metropolitan The Company Indicated above is referred to a	fower Life Insurance Company s "the Company".
is form was designed to cor	the state of the s	ide Act (HIPAA) tules.
or underwriting and clair authorize:	noly with the requirements of the Health insurance rollability and Secondary no settlement purposes regarding me or any child(ren) under the agoly medical facility; any other medical entity; any insurer; any consumer reports information about me or such child(ren), including:	
 cersonal information and 	ordata, e lost ten (10) years, including medical information, records, and data (such a escribed; medical tast results, information about sexually transmitted diseases	s: office visits; patient treatment; s and other similar information);
 information related to all information records and 	cond: and drug abuse and cleatine in. I data relation to Acquired Immune Deficiency Syndrome (AIDS) or AIDS relate	ed conditions, including Human
The Company to rediscluse	data relating to mental illness. Information received pursuant to this Authorization as authorized by me in v	writing or as otherwise permitted by
	nd obtain: consumer; investigative consumer; or motor vehicle reports ociate, financial institution, or government agency to give the Company any ions; driving record; finances, character; reputation; and aviation activities.	information or data that it may have
understand that:	ata that the Company receives pursuant to this Authorization will be used an	nd maintained by the company as
described in the Company All or part of the informati	's Privacy Notice, a copy of which was given to me 's Privacy Notice, a copy of which was given to me on, records and data that the Company receives pursuant to this Authorization, records and used by: any reinsurer; any Company employee; or any affiliate for the Company on the insurance applied for or on existing insurance with	on may be disclosed to MiB. Such
performs a business service	e for the Company of the inscitutor assure for all	
 Information related to alcomation 	phoj and ding against that this desti discipled to the comband was an beautiful	autarione toctuding federal nites
 Medical information, reco- issued by Hearth and Hun such information by health 	rds and cata disclosed may have deen subject to leading this standards for the training services, 45 CFR Parts 160-164. These rules set forth standards for the training providers and health plans. Once disclosed to the Company, this inferior	mation may no longer be subject to
thase laws or regulations. - information obtained puts	suant to this Authorization about major such child(ren) may be used, to the e	extent permitted by law, to determine
the incurability of other is	imily members.	
 If underwriting determine 	is that an investigative consomer report is record, and as an area	Courage taboring agency and
I am not required by law insurance in addition, he	to sign this Authorization, but it is do not, the company with the beaution pursually care provider(s) or health care plants) asked to release information pursually care provider.	
condition treatment or Di	ayment for treatment or other benefits on my signing it. o 24 months from the date on this form or sconer if prescribed by law, I may is that I have revoked this Authorization. Any action taken before the Company I	evaled it at any time by writing to the
- 1 hours a mark to correive a	a copy of this form. m is as valid as the original form.	
		Date _/1//1/07
SIGNATURES: (If a Proposed Insured is under	Print Name of Proposed Insured #1 Allin Lipice	5 Date of Birth 6-19
age 18, the Parent	The state of the s	Date
or Guardian, (circle one) is to sign on	Print Name of Proposed Insured #2	Date of Birtly.
line for such child.)		Date 11/11/07
بنياس ا	witness	

9187928287 33:11 8002/22/10

Check the appropriate company.

Page 5 of 6 received at 1/22/2008 11:28:49 AM [Eastern Standard Time] on server AS-BWTRFAXSVR06.

there eligertines intologo, se	Proposed insured:		
	☐ Metropolitan Life Insurance Co	mpany "I First MetLif	e Investors Insurance Company
Authorization	M New England Life Insurance Co	mpany 🦳 Metropolita	in Tower Life Insurance Company
	The Company indicate	ed above is referred to	o as "the Company".
	the state of the House	ance Portacities and Accoun	rability Act (HIPAA) rules
This intertwee designed to 40mg	settlement purposes regarding me or	any child(ren) under the	age of 18 named below,
- Annual and material and Anti-	nedical facility; any other medical entity; an	y insurer; any consumer rep	orting agency; and the MIB Group, Inc.
(MIR) to give the Company In	ormation about me or such child(ren), inclu	ding:	
			h as office visits' patient treatment
 entire medical file for the library pressure in the library press	ist ten (10) years, including medical infolition abo	ut sexually transmitted disea	ases and other similar information);
- information resolute and d	3.9 19191-UU to recontro mandre panciency	SAUDIDING (MIDS) OF MIDS 14	and the Contractions' and
	als relating to mental filness. formation received pursuant to this Authori.		
1 . 61. 1			,,
	obtain consumer; investigative consumer; o	or motor vehicle reports.	and year si teds such as a consequence
A Comment of the American Control of the Party	iara i kancial instruitori ias govessibest da	Bir A 'n Class are conclours a	uh lutotularion or data man ir mah nave
about: occupations: avocatio	is; driving record; finances; character; reput	ation; and aviation activities	•
I understand that:	that the Company receives pursuant to the	s Amhorization will be used	and maintained by the company as
	rivacy Notice, a copy of which was given to records and data that the Company receiv		ation may be disclosed to MIB. Such
An des sangues a prophies	or the Company on the insurance applied to	er or on existing insulance v	vith the Company Information may also
a information related to alcoh	i posobsin need sent jasuse that has been disclosed t	o the Company may be prof	tected by Federal Regulations 42 CFR
	1 -1 -0 - A 42 A 43 A 43 B B 44 B B 45 B B 46 B B 10 B 11 B 12 B	in recierar ariu scare 19775 G	r regulations, including lederal rules
ووقوم الماشم مطمله والمارات	Connect AS CAR Parts (Black) HA (CASE CUL	et sechenne Standards for ta	6 026' High (felicite and historia) as
such information by health :	are providers and health plans. Once discin	fed in the courbant, rus in	ounation may no longer be surject to
those laws or regulations	and the second s	hildrent may be used to th	e extent permitted by law to determine
• Information netrained earsur	nt to this Authorization about me or such o	tutquent utal of asea" to ru	e their political by ising to obtaining
the insurability of other fam	are zo culta svill ably be discipsed as desmitti	ed by applicable law.	
• Information relating to rity	nat an investigative consumer report is nee	ded, I will be contacted by t	he consumer reporting agency and
وويجم وفقم مرورهم أساسي المارين الماري	vinite proparation		
the second second by the second to	connectus Authorization, but it LAN NOT 1884	Company will not be able to	underwrite my application for life
incorpora la addition bealt	a care provider(s) or bealth care plants) ask	ed to resease information br	issuant to this Author zation can not
	and the transfer of Athan heater to an investigation	JONNIA II.	
أناهم الأرب مستسمين عاريق العا	4 many at from the data on this form of soor	Jet il Glascuped by ISM i Mig.	y revoke it at any time by writing to the
Company and advising it the	i I have revoised this Authorization. Any act	on taken beiore the Compar	ry has received my revocation will be valid.
• I have a right to lereive a c	opy of this form.		
A photocopy of this form	is as valid as the original form.		
		4 Nove - C 11	n 10 1707
SIGNATURES:	Proposed Insured #1 XXa/sa		
(!f a Proposed		Intelligher Sch	wartz Date of Birth 43/15/1923
Insured is under	Frint Name of Proposed Insured #1	POICE THE PARTY	man name of pittingstructures
age 18, the Farent	Access to the second second second		Date
or Guardian (circle	Proposed Insured #2		
one) is to sign on line for such child.)	Frint Name of Proposed Insured	·	Date of Birth
	The state of the s	M	Date /2/18/2007
· (************************************	Witness		Date
· -			
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Page 6 of 6 received at 1/22/2008 11:28:49 AM [Eastern Standard Time] on server AS-BWTRFAXSVR06.

C	heck the appropriate company.	
Authorization	roposed Insured: J Metropolitan Life Insurance Company	
	The Company indicated above is referred to as "the	Company".
This form was designed to comply	with the requirements of the Health Insurance Portability and Accountability Act extrement purposes regarding me or any child(ren) under the age of 1	· DIPAAI RIIPS
For underwriting and claim set authorize: • Any medical practitioner; any medical practitioner;	edical facility; any other medical entity; any insurer; any consumer reporting age	ncy; and the MIB Group, Inc.
 (MIB) to give the Company into personal information and da entire medical file for the last 	mation dependence including medical information, records, and data (such as: offici- it ten (10) years, including medical information, records, and data (such as: offici- itiod; medical test results: information about sexually transmitted diseases and o	ulelte: nationt treatment:
information related to alcoh	or and dridy obosy the dimmune Deficiency Syndrome (AIDS) or AIDS related confi	3(t(002) #tid
 information, records and da information, records and da The Company to redisclose info 	ta relating to mental illness. ormation received pursuant to this Authorization as authorized by me in writing	or as otherwise permitted by
 applicable law. The Company to request and of Any employer, business associations. 	obtain: consumer; investigative consumer, or motor vehicle reports. ate, financial institution, or government agency to give the Company any informatic to driving record; finances; character; reputation; and aviation activities.	ation or data that it may have
understand that:	that the Company receives pursuant to this Authorization will be used and main	ntained by the company as
described in the Company's r	that the Company receives notice as given to me. records and data that the Company receives pursuant to this Authorization may receive and used by: any reinsurer; any Company employee; or any affiliate or it or to company on the insurance applied for or on existing insurance with the Company on the insurance applied for or on existing insurance with the Company on the insurance applied for or on existing insurance with the Company on the insurance applied for or on existing insurance with the Company on the insurance applied for or on existing insurance with the Company on the insurance applied for or on existing insurance with the Company on the insurance applied for or on existing insurance with the Company or the	A pe disclosed to Mip. Shai
be disclosed as otherwise req	ured or permitted by applicable larger to the Company may be protected by	Federal Regulations 42 CFR
part 2. This information may Madical information, records	tend trug above that the provided in this Authorization, be redisclosed as provided in this Authorization, and data disclosed may have been subject to federal and state laws or regulate Services, 45 CFR Parts 160-164. These rules set forth standards for the use, making providers and health plans. Once disclosed to the Cumpany, this information	ons, including federal rules
those laws or regulations. Information obtained pursua	nt to this Authorization about me or such child(ren) may be used, to the extent	permitted by law, to determine
 Information relating to HIV t If underwriting determines th 	est results will only be disclosed as perfilted by applicable contacted by the consu- nat an investigative consumer report is needed, I will be contacted by the consu-	mer reporting agency and
interviewed in connection w I am not required by law to insurance. In addition, health	oth its preparation, so if I do not, the Company will not be able to underwisign this Authorization, but if I do not, the Company will not be able to underwing care provider(s) or health care plants) asked to release information pursuant to	rite my application for life a this Authorization can not
condition treatment or paym This Authorization will end 2-	then too treatment of other benefits of my signify as the law. I may revoke the months from the date on this form or sooner if prescribed by law. I may revoke the have revoked this Authorization. Any action taken before the Company has rec	t at any time by writing to the
 I have a right to receive a co A photocopy of this form 	is as valid as the original form.	
SIGNATURES:	Proposed Insured #1 Hana Salamon Print Name of Proposed Insured #1 Hana Salamon	Date 12/17/07
(If a Proposed Insured is under	Print Name of Proposed Insured #1 Hana Salamon	Date of Birth 1/12/1931
age 18, the Parent or Guardian, (circle	Proposed insured #2	Date
one) is to sign on line for such child.)	Print Name of Proposed Institled	Date of Birth
	Witness My Mary	Date
	THE RESIDENCE OF THE PARTY OF T	INL
ini	DÍLMÁMÍ MÍÐ Í MÍÐVAÐÍ ÞÍLÐÁLÁÐ Í DÓRÞÁR Í MÓLÍ ÞÁRÐ Í HEIÐ ÞER Í HAFR Í HAFR Í HAFR Í HAFR Í HAFR Í HAFR Í HAF	li l

From: Berry, Benjamin [Benjamin.Berry@ic.fbi.gov]

Sent: Sunday, July 27, 2008 4:59 PM

To: Mostecak, Stephen Subject: Re: Bank

Steve: Never heard of this "bank." Sounds fraudulent to me. A check with the New York State Banking Department would give you a definitive answer. Also, about six months ago I was transfered out of the bank fraud

area. Hope this is helpful. Regards, Ben

From: Mostecak, Stephen To: Berry, Benjamin

Sent: Fri Jul 25 10:13:31 2008

Subject: Bank

Hi Ben:

Came across your name on Dave Rosenzweig's External Crimes contact list. Quick question if I may, Sir. I'm investigating several suspect Stranger Owned Life Insurance policies in Brooklyn. An accountant of the insured indicates that this insured has a bank by the name of **Berkshire and Abrle** in Brooklyn, NY. I can't find this name anywhere? Might you have heard of it? I think it's just part of the scam......Thanks.

Steve

Stephen J. Mostecak

Principal Investigator

AIG World Investigative Resources (AIGWIR) Fraud Investigation Division

P.O. Box 372

West Nyack, NY 10994

Office: 845.398.0675; E-Fax: 1.866.667.8514

Cell: 917.862.2862

E/Mail: Stephen.Mostecak@AIG.com

F.I.D. Intranet Site: http://aignetprod.aig.com/cffid

The information in this email (and any attachments hereto) is confidential and may be protected by legal privileges and work product immunities. If you are not the intended recipient, you must not use or disseminate the information. Receipt by anyone other than the intended recipient is not a waiver of any attorney-client privilege or work product immunity. If you have received this email in error, please immediately notify me by "Reply" command and permanently delete the original and any copies or printouts thereof. Although this email and any attachments are believed to be free of any virus or other defect that might affect any computer system into which it is received and opened, it is the responsibility of the recipient to ensure that it is virus free and no responsibility is accepted by AIG World Investigative Resources, Inc. or its affiliates, either jointly or severally, for any loss or damage arising in any way from its use.



AIG World Investigative Resources (AIGWIR)

P.O. Box 372

West Nyack, NY 10994

845,398,0675 - Voice

1.866.667.8514 - Easylink Fax

E-mail: stephen.mostecak@aig.com

TO:

Jim Bilello, MetLife Fax: 908.655.9901 ibilello@metlife.com

FROM:

STEPHEN J. MOSTECAK

Principal Investigator

DATE:

May 30, 2008

RE:

Hana Salamon

OF PAGES: 2

(Including this cover sheet)

Hi Jim:

This request is regarding Hana Salamon, DOB: 1.12.1931.

Please consider this a Special Investigations Unit request in support of an internal fraud investigation to determine whether agents of American General Insurance Company may have committed insurance fraud against AIG involving a suspect IOLI/SOLI investigation.

American General has issued a life policy on Hana Salamon and I am aware that Ms. Salamon has applied for life coverage from MetLife.

I attach a copy of Hana Salamon's signed authorization. As such, may I request a copy of the policy application, and any financial disclosures, that Hana Salamon has provided MetLife, in furtherance of my investigation?

Thank you,

Stephen Mostecak Principal Investigator

AIG World Investigative Resources

Fraud Investigation Division

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May 30 08 02:01p

Stephen Mostecak

845-398-0675

PAGE 18/92 CRIMP: 8603213085 12/18/2007 16:16

12/13/2007 01:34 FAX 7188535511

HALPERT

₩ 005/007

Ald Life Insurance Company, Wilmington, DE American General Life Identifica Company, Houston, TX

The United States Life Incurrence Company in the City of New York, New York, NY The above listed life insurance company ("Company") as selected on page one of this application is responsible for the obligation and payments of banefits under any policy that it may issue. No other company is responsible for such obligations or payments.

Agreement, Authorization to Obtain and Disclose Information and Signatures

Agreement, Authorization to Ubtain and Disclose Information and Signatures

I, the Primery Proposed insured and Owner signing below, agree that I have read the statements contained in this application and any attachments or they have been read to the. They are true and complete to the best of my knowledge and baller. I understand that this application; (I) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the basis for any policy and any rider(s) issued. I understand that any misrepresentation materially affects the acceptance of the risk and (2) the policy is within its contestable period.

Except as may be provided in any I limited Temporary Life Insurance Agreement Lunderstand and acceptance of the Except as may be provided in any I limited Temporary Life Insurance Lunderstand and acceptance.

risk; and (2) the policy is within its confestable period.

Except as may be provided in any Umited Temporary Life Insurance Agreement, I understand and agree that even it I paid a premium no Except as may be provided in any Umited Temporary Life Insurance Agreement, I understand and agree that even it I paid a premium for the issued policy insurance will be in effect under this application, or under any new policy or any rider(a) issued by the Company, unless or under any proposed insurad(a) that would change the answers to any questions the following conditions are met: (1) the policy has been delivered and accepted and degree that fall three conditions above are not has been paid; and (3) there has been no change in the health of any Proposed Insurad(a) that would change it the appropriate above are not in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not in the application before items (1) in this paragraph have occurred. I understand and agree that if all three conditions above are not in the application before items (1) in this paragraph have occurred. I understand and agree that if all three conditions above are not in the expectation before items (1) in this paragraph have occurred. I understand and agree that if all three conditions above are not in the expectation before the conditions are refunded.

United Temporary Life Insurance Agreement (*) In 10.11 — If I have received and accepted the ITI IA. I understand and agree that it is paid to the company of the company of the company are not accepted and accepted the ITI IA. I understand and agree that it is paid to the company of the company of the company are not accepted and accept

loss occurs before premiums are refunded.

United Temporary Life Insurance Agreement ("LTLA") — If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insurad under the life policy (and the Other Proposed Insured under a joint insurance is available only on the life of the Primary Proposed Insurad under the life policy (and the Other Proposed Insured under the life policy (and the Other Proposed Insured under the life policy (and the Other Proposed Insured under the life policy (and the first modal) premium is submitted with and survivorable life policy, if applicable) and only if the following four conditions are met. (1) the full first modal) received is application and paid; and (2) only "no" answers have been truthfully given to the Health and Age fluestions in section 15; and (3) Part A this application and paid; and (2) only "no" answers have been truthfully given to the Health and Age fluestions in use to a suitable with any riders or any accident and/or health Insurance.

I understand and acceptable to a count is authorized to appear risks or nack upon insurability make a protective contracts or waive any of the understand and acceptable to a submitted to a support risks or nack upon insurability make a protective contracts or waive any of the understand and acceptable to a support risks or nack upon insurability make a protective contracts or waive any of the understand and acceptable to the protection of the application and acceptable to the protection of the prote

Understand and agree that no agent is authorized to: accept risks or pass upon insurability, make or modify contracts; or waive any of the

I have received a copy or have been read the Notices to the Proposed Insured(s).

I give thy consent to all of the entities listed below to give to the Company, its legal representatives, American General Life Companies LLC ("AGLC") (an efficient syrice company), and offiliated insurers all information they have pertaining to medical consultations; treatments ("AGLC") (an effiliated syrice company), and offiliated insurers all information they have pertaining to medical prescriptional or any other information surgeries; hospital confinements for physical and/or mensal conditions; tas of drugs or alcohol; drug prescriptional are any other information could include terms such as: personal finances; habits: hazardous avecations, for me, my spouse or my minor children. Other information could include terms such as: personal finances; habits: hazardous avecations for my, my spouse or my minor children. Other information could include terms such as: personal finances; habits: hazardous avecations, my english care facility, pharmacy benefit outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility, pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance and the information obtained will be used by the Company to distance (1) elimination between (MIS).

organization; my employer, or the Medical Information sureau (MID).

I understand the information obtained will be used by the Company to determine: (1) bligibility for insurance; and (2) eligibility for benefits a under an existing policy. Any information gethered during the evaluation of my application may be disclosed to: reinsurers, the MIB; other under an existing policy. Any information gethered during the evaluation of my application or claim; me; any physician designated by oersons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by oersons or organizations performing business such information by law or as I may further content.

the; or any person or erucy requires to receive such incrimation by law or as a reply in order consent. I understand this consent has a same person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent has be revoked at any time by sending a written request to the Company. Attn: Underwriting Department at P.D. Box 1931, Houston, TX 77251-1931. De revoked at any time by sending a written request to the company, Atm: Underwriting Department at N.U. DOX 1931, Houston, 1A 7/231-1931.

This consent will be valid for 2A months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize ABLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. There is you wish to be inverviewed.

IRS Certification: Under penalties of perjury, I certify: (I) that the number shown on this application is my correct Social Security or Tax ID number, and (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out from (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

backup withholding and cross out to the same same same same same same same sam
Proposed Insured X Alaba Signature of parent or guardian) Primary Proposed Insured X If under age 15, signature of parent or guardian)
Other Proposed Insured X (If under age 15, signature of parent of guardian)
Owner (if other than Primary Proposed Insured) X Agast(s) Signature(s) Leadify that the information supplied by the Primary Proposed Insured(s)/Owner has been truthfully and accurately recorded on the
Writing Agent Name (please prior) Writing Agent Name (please prior) Writing Agent Signature X (Licensed resident agent if state required)
Wriding Agent Signature A

DMV REQUEST FORM

(Must be filled out completely)

Date: July 21, 2008

Investigator: Stephen Mostecak Casetrack Number: 2008-0293 Insured: Salamon, Hana Policy Number: U10022254L

Claimant: Claim Number: N/A

Type of Policy:

Life

What would you like run:

Confirm and Verify Driver's License Number #658906493 DOB: 1/12/1931 or 1/21/1931

Do you need Insurance Info?

Negative

Reason for information:

Life Insurance Investigation

If you are in the field and would like a plate # run please provide color, make, model and location of the vehicle and date and time of location.

In the State of NJ you must have Driver's License #, you can not run by name.

75 3	**************************************
	*RECORD EXPANSION FOR: SALAMON, HANA
	CLIENT ID#: 658906493
	SALAMON, HANA DOB: 01/12/1931 SEX: F
	4910 17 AVE 2J HEIGHT: 5-3 EYE COLOR: BLUE
	BROOKLYN NY 11204 COUNTY: KING
	MI #: S01411 09630 460888-31
	ID ONLY EXPIRATION: 01/12/2013
	*** END OF RECORD ***



Stephen Mostecak
Principal Investigator
Fraud Investigation Division

AIG World Investigative Resources Northeast Region

P.O. Box 372 West Nyack, NY 10994 Phone: 845.398.0675

Cell: 917.862.2862 Fax:1.866.667.8514

August 7, 2008

Mr. Joel Katz, Trustee 750 Forest Avenue – Apt. 25D Lakewood, NJ 08701

Re: Life Policy of Hana Salamon - # U10022254L - AIG American General - Issued 12/'07

Mr. Katz:

You, as well as Aaron Knopfler, are listed on the above policy of our insured, Hana Salamon. As part of our business practice, I am required to meet with you in person to discuss the Trust aspects of the policy set-up.

As such, kindly call me upon receipt of this letter at the above phone number so that we can schedule an appointment that is convenient for you.

Thank you very much and I anticipate an expedient response, sir.

Stephen Mostecak Principal Investigator

Certified Mail - RRR and Regular USPS Delivery

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DMV REQUEST FORM

(Must be filled out completely)

Date: July 21, 2008

Investigator: Stephen Mostecak

Casetrack Number: 2008-0293

Insured: Salamon, Hana

Policy Number: U10022254L

Claimant:

Claim Number: N/A

Type of Policy:

Life

What would you like run:

Confirm and Verify Driver's License Number #658906493 DOB: 1/12/1931 or

1/21/1931

Do you need Insurance Info?

Negative

Reason for information:

Life Insurance Investigation

If you are in the field and would like a plate # run please provide color, make, model and location of the vehicle and date and time of location.

In the State of NJ you must have Driver's License #, you can not run by name.

*RECORD EXPANSION FOR: SALAMON, HANA

CLIENT ID#: 658906493

SALAMON, HANA

DOB: 01/12/1931 SEX: F

4910 17 AVE 2J

HEIGHT: 5-3 EYE COLOR: BLUE

BROOKLYN NY 11204

COUNTY: KING

MI #: S01411 09630 460888-31

ID ONLY

EXPIRATION: 01/12/2013

*** END OF RECORD ***

845-398-0675

p.1

Page 1 of 16 received at 6/3/2008 8:31:03 AM [Eastern Daylight Time] on server AS-EWTREAXSYROE.

PARY I	Check the appropriate company.	Office Use Only:
Application for	C Metrope	Diltan Life Insurance Company
Individual and	C First Me	tLife Investors Insurance Company
Multi-Life	200 7017 A0	RESIDE FORM TORK, PTT 1117AG
Life Insurance	SOI BOULD	gland Life Insurance Company in Street, Boston, MA 02116-0700
	The Company indicated a	above is referred to as "the Company".
SECTION 1	1. PROPOSED INSURED #1	
Proposed	Name Hana	Salamon
insured(s)	Street 4910 17th Ave Suite 2J	
	City Brooklyn	State NY 7H3 11204
*If less than 3 years, add	I YEARS AT THIS AMPROPER I I CONT.	25v 85 319-87-8296
prior residence address in Additional Information	Home Phone Number (718) 851-92 Work Phone Number (718) 928-54	Sest time to call: FROM 10:00
Section, Page 13.	Work Phone Number (718) 928-54	at Dayt.me (7 Evening to 65:00
	Cell NDOUS MITUDEL	Print number to call: 图 Hours T Work D Ce
	Driver's License Number	State
	License Issue Date	License Expiration Date
	Marital Status 73 Single 36 Marned	П Separated П Divorced П Widowed
	Date of Birth 01/12/31	State/Country of Birth Romania
	Sex 3 Male of Female	Net Worth \$ 10,000,000
	Annual Farmed Income 5 190,000	Annual Unearned Income 5 50,000
٠	Employer's Name SELF EMPLOYED	
NOTE:	Cares 4917 17th Ave Guite 21	
P.O. Box numbers		
CANNOT be accepted for street addresses.	City ta oddyn	State NY Zip 11284
ior sheet addresses.	Position/Title/Duties Artist	Length of Employment 48
	2. PROPOSED INSURED #2	
	Life 2, Shouse, Designated Life, Person to be	covered under Applicant's Walvar of Premium Benefit
	Relationship to Proposed Insured #1	•
	1	
If address is same	Street	
as Proposed	37666	
	City	
Insured #1.	City	State 7in
	Years at this address* SSN/	State 2ip
Insured #1,	Years at this address* SSN/	Tax ID State Zip
Insured #1,	City	State 2ip
Insured #1,	City	State 2ip Tax ID Best time to call: 3 Daytime O Evening Best number to call O Home O Work of Call
Insured #1,	City	State Zip
Insured #1,	City	State Zip
Insured #1, write "SAME". ADDITIONAL INSUREDS:	City	State 2ip
Insured #1, write "SAME". ADDITIONAL INSUREDS: See Supplemental	City	State Zip
Insured #1, write "SAME". ADDITIONAL INSUREDS: See Supplemental	City	State Zip
Insured #1, write "SAME". ADDITIONAL INSUREDS: See Supplemental	Years at this address* SSN/ Home Phone Number () Work Phone Number () Cell Phone Number () Driver's License Number Issue Date Mantal Status () Single) Married Date of Birth Sex] Male] Female	State 2ip
Insured #1, write "SAME". ADDITIONAL INSUREDS: See Supplemental	City	State Zip
Insured #1, write "SAME".	City. Years at this address* SSN/ Home Phone Number () Work Phone Number () Cell Phone Number () Driver's License Number Issue Date Mantal Status (T Single Married Date of Birth Sex Male Female Annual Earned Income \$ Employer's Name	State 2lp
Insured #1, write "SAME". ADDITIONAL INSUREDS: See Supplemental	City_ Years at this address*SSN/ Home Phone Number () Work Phone Number () Cell Phone Number () Driver's License Number Issue Date Mantal Status (T Single T Married Date of Birth Sex T Male T Female Annual Earned Income \$ Employer's Name Street	State 2lp
Insured #1, write "SAME". ADDITIONAL INSUREDS: See Supplemental	City	State 2ip

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	if more sp	sace is needed, please	use the	Additional I	nformat	tion Section	. Page 13.
SECTION 1 Proposed Insured(s)	A. Are any IF YES, pi Amount	IDENT SPOUSE or MI persons to be insured a lease provide. It of existing insurance	depende on spaus	e of Praposed			CT YES Ø N
	1	t of insurance applied				ured 🐛	
	(F YES, pl	any persons to be insure lease provide; t of existing insurance				_	M KES 24 M
		t of insurance applied			l		
	Amount Amount 2. Are a	t of existing insurance t of insurance applied all siblings of this depen- lase provide details:	on mothe for on m	er/guardian other/guardia	an	\$_ \$.	O YES 7 N
SECTION 2 Existing or Applied For Insurance	A. Do any for life	NG or APPLIED FOR of the Proposed Insured insurance (L) or annuity ompany?	s or Owne	ers have any cts with this	or any	or applied	
	i						
	IF YES, pr	ovide details on Propos	ed insure	d only:		Owner	O YES TIN
ome states require the ompletion of an additional form. See	IF YES, pr Proposed Insured (#1, #2, other)	ovide details on Propos Company	insure (L A)	only: Amount of	Yeur af	Accidental Death Amoun	Existing or
ome states require the ompletion of an additional form. See instructions on the cover of the Replacement	Proposed Insured		Type	Amount of		Accidental	Existing or
ome states require the ompletion of an additional form. See instructions on the cover of the Replacement	Proposed Insured		Type	Amount of		Accidental	Existing or Applied for
ome states require the ompletion of an additional form. See instructions on the cover of the Replacement	Proposed Insured		Type	Amount of		Accidental	Existing or Applied for TETA
iome states require the completion of an additional form. See instructions on the cover of the Replacement	Proposed Insured		Type	Amount of		Accidental	Existing or Applied for TETA
IF YES Some states require the completion of an additional form. See instructions on the cover of the Replacement forms Package.	Proposed Insured (#1, #2, other)	Сапрацу	Type (L A)	Amount of Insurance	issue	Accidental Death Amoun	Existing or Applied for T E T A T E T A T E T A
come states require the completion of an additional form, See instructions on the cover of the Replacement	B. Do any insurance (LTC) apple YES, pro transaction of any or an	of the Proposed Insured e (D) or critical illness in alied for or planned with ovide. Proposed Insure	is have any surance (Ch. THIS Coon, has the surrender of premium rectionnaire cement for the control of the con	application or long terr impany or its other) ere been, or transaction; if /consideration annuity or ce and Disclos	for disal m care ii affiliate —— Typ will ther can; with in; or ch other life	Accidental Death Amount Death Deat	Existing or Applied for Applie

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	If more space is needed, p	ease use the Additional Information Section, Page 13.
SECTION 3	IDENTITY of PRIMARY O	
Owner	ill Proposed insured #1 Com	
	☐ Proposed Insured \$2 Com	•
•	(7) Other Person Complete Complete Question	
	1. OWNER IDENTIFICATE	• • •
H U.S. Driver's License already		ly provided on page 1 (Proposed Insured) reen Card IT Passport IT Other ID Card
provided no further	Issuer of ID New York State	ID ksie Date 06/07/07
information is required.	ID Reference Number 65890	6493 ID Expiration Date 01/12/13
	2. OWNER other than Pi	
NOTE:	Name	
P.O. Box numbers CANNOT be accepted	Street	
for street addresses.	City	State Zip
	Phone Number ()	
IF CUSTODIAN	Citizenship	Country of Permanent Residence
is acting on behalf of a minor under UTMA/	Date of Birth	SSN/Tax ID
UGMA, please complete	Relationship to Proposed ins	uret(s)
Additional Owner Form in Supplemental	Employer's Name	
Forms package.	Street	
	City	State Zip
	Position/Title/Duties	Length of Employment
	177 Check if you wish owners?	p to revert to insured upon Owner and Contingent Owner's death.
	3. ENTITY/TRUST AS OW	NER
	Entity/frust Type:	grporation II S Corporation II LLC rjership II Sole Proprietorship II frust
IF TRUST		Date of Trusty
Complete Trust Certification form	Name of Entity/Trust	and to be established
in Supplemental	1	
Forms Package.	Street	
	City	StateZip
IF BUSINESS	· ·	ship to Entity
Complete Business	1 '	Business Phone
Supplement form In Supplemental	is entity publicly traded?	
Forms Package.		the following documents: (Indicate which one you are supplying.)
		phration/Government Issued Business License
	Till Operating A	
	☐ Partnership Agre ☐ Government Issu	ed Certificate of Good Standing
		-
JAMEN I.		FFS AND ENGINEER IN IN NEW AND REPORTED WITH A MARKET IN MARKET IN
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4	If more space is needed, please use the Additional Information Section, Page 13.
SECTION 4 Beneficiary(les)	NOTE: Federal law states if you leave someone with special needs any assets over \$2,000, they may lose eligibility for most government benefits.
	Contingent Beneficiaries ORLY (Ticheck here if you want any and all fiving and future natural or adopted children of Proposed Insured 41 to be included as Contingent Beneficiaries. Name any living children as beneficiaries below.
Check here AND DO NOT COMPLETE	Name
if Primary Beneficiary is same as Trust or Estity Owner.	StreetStateZip CitySSN/Tax ID
If there is a court appointed legal Guardian for Beneficiary, provide name and address in Additional Information	Relationship to Proposed Insured(s) Percent of Proceeds [Multiple Barefootes will receive an equal percentage of proceeds unless cureroise featureed.) IT PRIMARY IT CONTINGENT
Section, Page 13.	Name
	City
	Relationship to Proposed Insured(s) Percent of Proceeds(Multiple Senefidaries will receive an equal percentage of proceeds unless otherwise instructed.) CI PRIMARY © CONTINGENT Name
	Street
	Relationship to Proposed Insured(s) Percent of Proceeds(Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise insurated.)
SECTION 5 Custodian acting for Minor Beneficiary(les)	Custodian's name as custodian for Uniform Transfers (or Gifts) to Minors Act. Street
Deficiencial y(res)	CityStateZip

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Information Regarding	Product Name Guscanteen Advantage NL
Insurance Applied for	Face Amount \$ 10,000,000 (Complete Personal Financial Supplement if \$1,000,000 or more.) IT Group Conversion* Optional Benefits and Riders: IT Guaranteed Survivor Plus Purchase Options (GSPO+)* Option Period(s): IT Guaranteed Survivor Income Benefit (GSIB) IT Term Rider Specify: \$
Complete these forms, if applicable: -ADBR -Enricher/Equity Additions -Group Conversion -GSPO+ These forms can be found in the Supplemental	☐ Life Guarantees Purchase Option (EGPO) ☐ Acceleration of Death Benefit Rider (ADBR)* ☐ Enricher Options (PAIR-VABR)* Specify. ☐ Long Term Care Guaranteed Purchase Option (LTC-GPO) ☐ Disability Warver (DW) Specify: ☐ Other Special Requests/Other: ☐ Save Age ☐ Specific Policy Date
Forms Package.	Check here if C alternate OR C additional policy is requested and provide full details below. Include SIGNED & DATED illustration for each policy requested. 2. ADDITIONAL INFORMATION for WHOLE LIFE PRODUCTS Do you request automatic payment of premium in default by Policy Loan for traditional plans), if available? Dividend Options: D Paid-up Additions T VAI Equity Additions* D Premium Reduction Cash Dividend Other
For Variable Life, also complete Variable Life Supplement.	3. ADDITIONAL INFORMATION for UNIVERSAL LIFEVARIABLE LIFE PRODUCTS Planned Premium Amount: Year 1 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$

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SECTION 7	1. PAYMENT MODE	(Chack one)		
Payment	Direct Bill:	S Annual	☐ Semi-Annual	☐ Quarterly
Information	Electronic Payment	Monthly		_ ,,
If Monthly Electronic	Special Account:	•	t Allatment	☐ Salary Deduction
Payment is chosen, complete Electronic	Additional Details:		•	— July Production
Payment Account				
Agreement				
	2. SOURCE of CURR			
				loney Market Fund Disaving
				. IT Certificate of Deposit
	☐ Loans □			
NOTE: It is Company rolky to	3. PAYMENT			
not accept cash, traveler's	Amount collected with (Must equal at least one mor	application \$		
checks, or money orders as a form of payment for	Premium Payor:	киу ргеглоту		,
Variable Life Products.	☐ Proposed Insured #1	CJ Prop	osed Insured #2	51 Primary Owner
	Other	·		4
	Name			
	•			
	1			
	4. BILLING ADDRES			
	☐ Proposed Insured #1	Address	O Proposed I	nsured #2 Address
	Primary Owner's Ado			
	① Other Premium Payor			
	Sveet			
			St	ate Zip
	☐ Special Arrangement	S		
	V			
E-Mail	Proposed Insured #1			
Addresses	Proposed Insured #2			
optional	Primary Owner			
	Joint/Contingent Owner			

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SECTION 8	The following questions are to be covered by any riders applied for.	answered for ALL persons to be insure	ed, including thos
General Risk Questions	Within the past three years has flown in a plane other than as airline or have plans for such a	a passenger on a scheduled ctivity within the next year?	O YES & N
	IF YES, complete a separate Avia applicable Proposed Insured.	tion Supplement for each	
	Underwater sports - (SCUBA d Sky sports - (skydiving, hang g similar activities);	ving, skin diving, or similar activities); iding, parachuting, ballooning or	ed in
If you need more space, please use the Additional Information Section, Page 13	Racing sports - (motorcycle, au Rock or mountain climbing or Bungee jumping or similar acti IF YES, complete a separate Avo applicable Proposed insured.	nties?	Ü YES Ø N
	3. Within the next two years intend to travel or reside	cutside the U.S. or Canada?	∏ YES ≯ N
		se provide Proposed Insured,	
	duration, country and purpose		
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured IF NO, please provide details:	U.S. Citizens?	Ø YES.⊓ N
	4. CITIZENSHIP/RESIDENCY A. Are all dersons to be insured IF NO, please provide details: Proposed insured(s) Visa Type/ID	d U.S. Citizens? Country of Citizenship Visa Number	Ø YES.⊓ N
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured IF NO, please provide details: Proposed insured(s) Visa Type/ID Expiration Date	Country of Citizenship Visa Number Length of Time in U.S.	Ø YES.⊓ N
	4. CITIZENSHIP/RESIDENCY A. Are all dersons to be insured IF NO, please provide details: Proposed insured(s) Visa Type/ID	Country of Citizenship Visa Number Length of Time in U.S.	Ø YES.⊓ N
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured IF NO, please provide details: Proposed insured(s) Visa Type/ID Expiration Date CT Check here if currently applying	Country of Citizenship Visa Number Length of Time in U.S.	Ø YES.CI N
	4. CITIZENSHIP/RESIDENCY A. Are all dersons to be insured IF NO, please provide details: Proposed insured(s) Visa Type/ID Expiration Date CT Check here if currently applying B. Are all persons to be insured	Country of Citizenship Visa Number Length of Time in U.S for a Social Security number.	Ø YES.⊓ M
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured IF NO, please provide details: Proposed insured(s) Visa Type/ID Expiration Date CI Check here if currently applying B. Are all persons to be insured United States?	Country of Citizenship Visa Number Length of Time in U.S for a Social Security number. permanent residents of the	Ø YES.CI N

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SECTION 8	The following questions are to be answered for ALL persons to be insured, incovered by any riders applied for.	chaing those
General Risk Questions (continued)	thew; etc.) or niconne substitutes te.g., pater, govern	J YES Ø NO
	Proposed Insuredis) Date Last Used	
	Туре	
	Amount/Frequency	
if you need more space, please use the Additional information Section, Page 13.	6. Has ANY person to be insured: EVER had a driver's license suspended or revoked. EVER been convicted of DUI or DVI; or had, in the last five years, any moving violations? IF YES, please provide Proposed Insured, data and violation. Proposed Insured(s)	CJ YES 2J NK
3220017 - 55		
	Details:	
	7. Has any person to be insured EVER had an application for life, disability income or health insurance declined, postponed, rated or modified or required an extra premium? IF YES, please provide details:	O YES Ø N
	Proposed Insured(s)	
	Details:	
	8. Are all persons to be insured: actively at work; or a homemaker performing regular household duties; or a student attending school regularly? 1F NO, please provide details:	Ø YES TIN
	Proposed insured(s)	
	Details:	
Maria de la companya	9. LONG TERM CARE GUARANTEED PURCHASE OPTION RIDER	
Please answer these questions only if requesting the Long Term Care Guaranteed Purchase Option Rider.	A. Does any person to be insured under this rider currently use any mechanical equipment such as: a walker; a wheelchair; long leg braces;	O YES O I
	Proposed Insured(s) B. Does any person to be insured under this rider need any assistance or supervision with any of the following activities: bathing; dressing; walking moving in/out of a chair or bed; toileting; continence; or taking medication?	•

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SECTION 1 Physician Information	1. PHYSICIAN	ractitioner or health ea	- facility of the same of the sky
	Physician Information for F	Proposed Insured 81 itioner or health care fa	l cility is known.
PLEASE NOTE:	Physician Name Slomowits Jose	iph Md	Phone Number (718) 851-8400
If FULL PARAMEDICAL exam is required.	Name of Practice/Clinic		_ Pax Number ()
completion of Medical	EASG 4P A		
questions is OPTIONAL but will expedite			State NY Zip 11219
your application	Date Last Consulted	Pasma	
	Findings, treatment given, medic	ation prescribed. If Non	
	Physician Information (1)	iodnar or nealth care fa	cility is known.
	Physician Name		Phone Number ()
	Name of Practice/Clinic		Fax Number ()
	Street		
	Date Last Contribed		State Z _p
	Findings, treatment given, medica	REBSON	
			e, check here ID.
SECTION 2	1. HEIGHT/WEIGHT		
Medical	Proposed Insured #1 He	ight	_ Weight
Questions	Proposed Insured #2 He	ight	Weight
	Has any Proposed Insured experie (greater than 10 pounds) in the p	nced a change in unles	
	IF YES, specify: Proposed insured #1 Pounds	lost	Pounds gained
	Proposed Insured #2 Pounds	lost	Pounds gained
	Reason :		

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SECTION 2 Medical Questions

(continued)

PLEASE NOTE:
If FULL PARAMEDICAL
exam is required,
completion of Medical
questions is OPTIONAL
but will expedite

your application.

2. Has a parent (?) or sibling (S) of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; diabetes; or mental diness? (I) NO

IF YES, Indicate below:

Proposed instruct (#1, #2)	Relationship to Proposed Insteed	Age if Living	Age at Douth	State of Health, Specific Conditions, Cause of Duath
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	គ្នាទ			
	OP OS			

3. Has ANY person to be insured EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had:

	Prop Insur		Prop			her osed
A. High blood pressure; chest pain; heart	YES	NO	YES	NO	,	No
attack, or any other disease or disorder of the heart or circulatory system?	o	o	0	ø	o	a
B. Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system?	ជ	ß	a	ø	0	0
C. Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; memory loss; Parkinson's disease; progressive neurological disorder; headaches; or any other disease or disorder						
of the brain or nervous system?	ø	O	מ	J	0	O

Details: If you answered YES to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Name of Physician Address if not already provided	Date/Suretion of Illness	Olagnosis/Severity Medications/Treatment
h			<u> </u>	

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	If more space is needed, please use the Addit	ional l	forma	ition S	ection	, Page	13. 1	1	
SECTION 2 Medical Questions	3. Has ANY person to be insured EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that heishe had:								
(continued)		Proposed insured #1		Proposed Insured #2		Prope	sed		
PLEASE NOTE: If FULL PARAMEDICAL	Di. Ukers; colltis; hepatitis, cirrhosis; or any other disease or disorder of the liver;	YES	NO	YES	NO	YES	-		
completion of Medical questions is OPTIONAL but will expedite your application	gailbladder; stomach, or intestines? E. Any disease or disorder of: the kidney; bladder; or prostate; or blood, protein or pus in the urine?	- 1	- 13	a	ri ri	a	n n		
your apprication	F. Diabetes; thyroid disorder; or any other endocrine problem(s)?	•	a	a	<u> </u>	0	o o		
	G. Arthritis; gout; or disorder of the muscles, bones or joints?	G	o		o		5		
	H. Cancer; tumor; polyp; cyst or any skin disease or disorder?	۳	a	0	σ	0	O		
	Anemia; leukemia; or any other disorder of the blood or lymph glands?	0	rı;	in in	ជ	0	۵		
	J. Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	۵	ø		œ	a	ם		
	K. Any disease or disorder of the eyes, ears, nose, or throat?	σ	0	o o	ÇI.	a	0		

Details: If you answered YES to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Hame of Physician Address If not already provided	Oute/Duration of Illness	Diagnosis/Severity Medications/Treatment
		-		
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SECTION 2 Medical	4. Has	ANY person to be insured:			ssed ## #1	Propi		Oth Propi	sted
Questions (continued)	und	rrently, or within the past six months der observation or received treatmer y medication? (including over-the-co- dications, vitamins, herbal suppleme	s, been it or taken unter	ස්	NO I	YES	KO	YES	
DI FASE NOTE:		the next six months, scheduled any	doctors	_					
If FULL PARAMEDICAL exam is required, completion of Nedical questions is OPTIONAl but will expedite	C. Du ele D. Du	ring the past five years, had a; ched ctrocardiogram; chest x-ray; or med iring the past five years, had any illn	ess, injury	.	o	ם	ø	0	
your application.	be	health condition not revealed above en recommended to have any; hosp rgeny; medical test; or medication?	italization;	ដ	U	a	0		ξ.
	me	TER been diagnosed with or treated ember of the medical profession for muna Deliciency Syndrome (AIOS)?		a a	a	a	5		ſ
	F. EV	TER used herola, cocaine, barbituate her drugs, except as prescribed by a other licensed practitioner?		3	3	5	5	0	t
etails: if you answer	us rec or an	unselor regarding the use of alcohole of drugs, except for medicinal pursewed treatment or advice from an ganization that assists those who has alcohol or drug problem? any of the above questions, please	poses; or	<i>(</i>)	c)	0	G	0	
Question Proposed Number No.	Insured	Name of Physician Address if not already provided	Date/Durario		~3 C.	Di Med	agansisi igations/	Saverity Treatmen	nt
			l .						
						······································			

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the this page for any additional information.

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Certification/ Agreement/ Disclosure					
Certification Regarding Sales Illustration Agent certifies that a signed illustration is no	on Agent must continued by it	heck the approp	riate stateme applied for is	nt below. not illustrate	d in this state
Cl. An illustration was signed and treatches the	a policy applic	ed for it is inclu	ided with this	s application.	
An illustration was shown or provided but is to the policy as issued will be provided no la	different from	n the policy a	pplied for.	An illustratio	n conforming
W No illustration conforming to the po	olley as applied for	or was shown or	provided pri	or to or at th	e time of this
application. An illustration conforming to the of lift illustration was only shown on a continuous.					r pailicy delivery.
An illustration was displayed on a computer but no printed copy of the illustration was provided no later than at the time of policy and policy information:	provided. An illust	ration conformin	ig to the poli-	cy as issued i	will be
1. Gender (as illustrated)	OM OF		Age		
2. Rating class (e.g. standard, smoker)		[7 Standard			J Smoker
3 Type of policy (e.g. L-98, Whole Life)_					
4. Initial Death Benefit \$					
S. Guaranteed Minimum Death Benefit	-	-	_	-	•
6. Dividend Option					
7. Riders					
Agreement/Disclosure I have read this application for life insurance knowledge and belief, all statements are true. My statements in this application and any amendment. This application and any: amendment(s); paramedical become part of the new policy. No information will be deemed to have been given the and any supplement(s). Only the Company's President, Secretary or Vice-Presipromise about Insurance; or (c) change or waive any Except as stated in the Temporary Insurance Agreement Owner and the full first premium due is paid. It will depend not be insured is the same as stated in the appreachment from a medical practitioner since the date.	e and complete, int(s), peramedical/mids), peramedical/mids and the Company unless the Company unless them of an application and Receipt, no inply take effect at the plication; and (b) no	I also agree that ledical exam and stated in this ess it is stated in this or change any contion, receipt, or polk insurance will take the time it is delivered	nt: upplement(s) and his application, is application an mact of insuran ty, effect until a point of its conditions in it	e the basis of a will be attached attached paramedical (ce. (b) make a bolicy is delivered dition of hearth	iny policy issued. Id to end Imedical exam, binding I to the

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Certification/ Agreement/ Disclosure (continued)

- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I intend to replace existing insurance or annuities, I have so indicated in Section 2, Question 2 of this application.
- . I have received the Company's Consumer Privacy Norte and, as required, the Life Insurance Buyer's Guide.
- . If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.
- I understand that receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount
 is associated with the acceleration and an administrative change will be required upon exercise of the benefit.

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:

The number shown in this application is my correct taxpayer identification number, and I am not subject to

backup withholding because:

- (a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, OR
- (b) the IRS has notified me that I am not subject to backup withholding. (If you have been notified by the IRS that you are rumantly subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)

I am a U.S. citizen or a U.S. resident alien for tax purposes.

(If you are not a U.S. citizen or a U.S. resident alien for tax purposes, please cross out this certification and complete form W-8BEN).

Please note: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

SIGNATUR	ES:	Signed at City, State Brewklyn AV Proposed Insured #1 Halla Salallow Proposed Insured #1 Halla Salallow
If not witnessing all signatures. Witness should		Proposed Insured #1 Halla Salatelle (age 15 or over)
sign next to the signature being witnessed.		Signed at City, State
		Signed at City, State Date
		Owner_ (If other than Proposed Insured) (If age 15 or over) If the Owner is a firm or corporation, include Officer's title with signature.
	F	Parent or Gwardian (If Owner or Proposed Insured(s) is/are under 18, sign here if not signed above.)
		Signed at City, State ProoKlyk NY Date 12/17/07 Witness to Signatures (Ucensed Agent/Producer)
		Please print Agent/Producer name Mayer Krawarsky

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Proposed Insured: Hans Salamon	•		Check the appropriate of	onepurty.	
New England Life insurance Company Metropolitan Americal Life insurance Company Metropolitan Tower Life insurance Company The Company indicated above is referred to as "the Company". INCOME					
the amount of coverage is \$1,000,000 and over. Salary of Draw \$ 100,000.00 Borus/Commissions \$		· Financial ·	D Methife investors	Insurance Company	General American Life Insurance Company Metropolitan Tower Life Insurance Company
Bonus/Commissions \$ Other Earnings \$ Source Spouse's Income \$ 100,000.00 Spouse's Income \$ Dividends/unterest \$ 50,000.00 Source		the amount of coverage		·me	
Dividends/merest (58,000.00 Source Net Rentals S Source S			Bonus/Commissions- Other Earnings Total Earned Income	\$ \$ \$	-
Assets Cash			Dividends/Imerest Net Rentals Other Unearned	\$\$	-
Total Assets \$ 10,000,000.00			Assets Cash Real Estate Business Equity Stocks/Bonds Other Assets	\$ \$ \$ \$ \$	Mortgages \$ Personal Loans \$ Other \$
Net Worth: _\$ 10,000,000.00		·	Will Pases	Total Assets \$ Total Liabilities -\$	0.00

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PART I	Check the appropriate company.	Office Use Only:
Application for Individual and Multi-Life Life Insurance	CT First Met 200 Pari Ave TNew Eng 501 Boriston	litan Life Insurance Company nue New York, hr 19166 tLife Investors Insurance Company nue New York hy 19166 fland Life Insurance Company Street, Boston, MA 02116-3700 bove is referred to as "the Company".
SECTION 1 Proposed Insured(s)	1. PROPOSED INSURED #1 Name Hana Street 4910 17th Ave Suite 2J	Salamon State NY Zip 11204
If less than 3 years, add prior residence address in Additional Information Section, Page 13.	Years at this address 15 SSN/4 Home Phone Number (718) 851-924 Work Phone Number (718) 926-54	Fax (D 319-82-9296 50 42 Sest time to call: FROM 10:00 50 60 60 60 60 60 60 60 60
NOTE: P.O. Box numbers CANNOT be accepted for street addresses.	Driver's License Number Ucense Issue Date Marital Status I Single Married Date of Birth 01/12/31 Sex I Male of Female Annual Earned Income \$ 100,000 Employer's Name SELF EMPLOYED Street 4910 17th Ave Suite 2J City Brooklyn Position/Title/Duties Artist 2. PROPOSED INSURED #2 Life 2, Strouge, Designated Life, Person to be of Relationship to Proposed Insured #1 Name	State License Expiration Date State Usense Expiration Date Separated ID Divorced ID Widowed State/Country of Birth Net Worth \$ 10,000,000 Annual Unearned Income \$ 50,000
as Proposed Insured #1, write "SAME".	City	State Zip
ADDITIONAL INSUREDS: See Supplemental Forms Package.	Mantal Status (T Single D Married Date of Birth	Expiration Date ☐ Separated ☐ Divorced ☐ Widowed State/Country of Birth Net Worth \$ Annual Unearned Income \$
	City	State Zip Length of Employment

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2	If more spa	ce is needed, please	use the	Additional I	nforma	tion Section.	Page 13.
SECTION 1 Proposed Insured(s) (continued)	3. DEPEND A. Are any p IF YES, ple Amount	ENT SPOUSE or Mil persons to be insured a ase provide. of existing insurance	NOR depende on spous	nt spouse? e of Propose	d Insure		YES Ø NO
	Amount of insurance applied for on spouse of Proposed Insured B. 1. Are any persons to be insured a dependent minor? IF YES, please provide: Amount of existing insurance on father/guardian					cn 5	YES 71 NO
	Amount (of insurance applied of existing insurance of insurance applied.	on mothe for on m	er/guardian other/guardia	ìn		
	IF NO, plea	siblings of this depend se provide details:	Jent Mino	r equally inst	ired?	C	YES 7 NO
SECTION 2 Existing or Applied For Insurance	A. Do any o for life in other cor	•	s or Owni A) contra	ers have any cts with this	or any	or applied d Insured Owner	
Some states require the completion of an additional form. See	Proposed Insured (#1, #2, other)	vide details on Propos Company	Type (L.A)	Amount of Insurance	Year of	Accidental Death Amount	Existing or Applied for
instructions on the cover of the Replacement Forms Package.							TE TA
							□A □E □A
							∏ E ∏ A
	B. Do any o	f the Proposed Insured	s have an	, annication	for dire	Litta	DE DA
	(LTC) appl	(D) or critical illness insided for or planned with ride. Proposed insured	iurance (C i THIS Co	i) or long ter	m care i	nsurance co en	YES 7 NO
Applicable replacement and 1035 exchange forms can be found in Replacement Forms Package.	2. REPLACE A. In connec this or an lapse, red transaction IF YES, com		on, has the surrender premium nyolving a	ere been, or transaction; Uconsideration annuity or or and Disclos	will the loan; wi on; or ch	re be with thdrawal;	
	B. is this an exchange under internal Revenue code section 10357						
	IF YES, com	plete the 1035 Exchang	ge Author	ization for (each at	fected pollo	y.
		n iniin iniini u in iinid					
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	if more space is needed, please use the Additional Information Section, Page 13.
SECTION 3 Owner	IDENTITY of PRIMARY OWNER (Check one.) 17 Proposed Insured #1 Complete Question 1 ONLY. 17 Proposed Insured #2 Complete Question 1 ONLY. 17 Other Person Complete Questions 1 and 2. 18 Entity Complete Question 3 ONLY.
If U.S. Driver's License already provided, no further information is required.	1. OWNER IDENTIFICATION ID U.S. Driver's License already provided on page 1 (Proposed Insured) ID U.S. Driver's License ID Green Card ID Passport ID Other ID Card Issuer of ID New York State ID Issue Date 06/07/07 ID Reference Number 6589(6493 ID Expiration Date 01/12/13 2. OWNER other than PROPOSED INSURED(S)
NOTE: P.O Box numbers CANNOT be accepted for street addresses.	Street State Zip
is acting on behalf of a minor under UTMA/ UGMA, please complete Additional Owner Form in Supplemental Forms package.	Phone Number () Citizenship Country of Permanent Residence Date of Birth SSN/Tax ID Relationship to Proposed Insured(s) Employer's Name Street State Zip
	Position/Title/Duties Length of Employment Length Length of Employment Length of Employment Length Length Length Length of Employment Length Length Length Length Length Length L
IF TRUST Complete Trust Certification form in Supplemental Forms Package.	Name of Entity/Trust Tuses to be estable with the Name of Trustee(s) Street
IF BUSINESS Complete Business Supplement form in Supplemental Forms Package.	Proposed Insured(s) Relationship to Entity Nature of Business Is entity publicly traded? TYES TO NO IF NO, please supply one of the following documents: (Indicate which one you are supplying.) The Articles of Incorporation/Government Issued Business License The Coperating Agreement Partnership Agreement Government Issued Certificate of Good Standing
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	If more space is needed, please use the Additional Information Section, Page 13.
SECTION 4 Beneficiary(ies)	NOTE: Federal law states if you leave someone with special needs any assets over 52,000, they may lose eligibility for most government benefits.
	Contingent Beneficiaries ONLY Theck here if you want any and all living and future natural or adopted children of Proposed insured #1 to be included as Contingent Beneficiaries, Name any living children as beneficiaries below.
Check here AND DO NOT COMPLETE If Primary Beneficiary Is same as Trust or Entity Owner.	NameStreetStateZip
 If there is a court	Pate of Birth SSN/Tax ID
appointed legal Guardian for Beneficiary, provide name and address in Additional Information Section, Page 13.	Percent of Proceeds (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed in PRIMARY IT CONTINGENT
•	Name
	Street State Zip
	Date of Birth SSN/Tax ID
	Relationship to Proposed Insured(s)
	Percent of Proceeds (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed
	PRIMARY CONTINGENT
	Name
	Street
	CityStateZip
	Date of Birth SSN/Tax ID
	Relationship to Proposed Insured(s) Percent of Proceeds (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed
SECTION 5	Custodian's name
Custodian	as custodian for
acting for Minor	under the Uniform Transfers (or Gifts) to Minors Act
Beneficiary(ies)	Street
	CityState Zip
	Relationship to Minor(s)

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SECTION 6 1. PRODUCT & FACE AMOUNT	tion, Page 13.
SECTION 6 1. PRODUCT & FACE AMOUNT	1
SECTION 6 1. PRODUCT & FACE AMOUNT Information Product Name Transport for Manage M	
Regarding Face Amount \$ 10,000,000 (Complete Personal Financial Supplement in	f \$1,000,000 ar more.)
Insurance Applied for	
☐ Guaranteed Survivor Plus Purchase Options (GSPO+)*	
Option Period(s):	
Term Rider Specify:	
☐ Life Guaranteed Purchase Option (LGPO)	
Complete these forms, Acceleration of Death Benefit Rider (ADBR) Complete these forms, Complete the complet	
if applicable:	
ADBR Inricher/Equity Disability Waiver (DW) Specify: Substitute Solution Specify: Substitute Specify: Substitute Solution Specify: Substitute Specific	
Additions	
•Group Conversion •GSPO+ Special Requests/Other:	
These forms can Save Age Specific Policy Date	
be found in	
the Supplemental UD Other	
Check here if (3 alternate OR (3 additional policy is requested and provide	to full dotails below
Include SIGNED & DATED illustration for each policy requested.	le foil details below.
2. ADDITIONAL INFORMATION for WHOLE LIFE PRODUCTS	
Do you request automatic payment of premium in default by Policy Loa	'n
(for traditional plans), if available?	(i) YES (i) NO
Dividend Options:	
☐ Paid-up Additions ☐ VAI Equity Additions* ☐ Premium Reduction	1
☐ Cash ☐ Accumulations/DWI	
Other	
3. ADDITIONAL INFORMATION for UNIVERSAL LIFE/VARIABLE	FILEE PRODUCTS
For Variable Life, also Planned Premium Amount: Year 1 \$ 456,873 Excess/Lump Sum \$ _	
Complete Variable Life Supplement. Duration of premium payments 23 9465	
Planned annual unscheduled payment (il applicable).	
Planned annual unscheduled payment (if applicable): \$	
Renewal Premium (if applicable), \$ 13	
Renewal Premium (if applicable). \$ 126, 5/3	
Renewal Premium (if approaller, \$ 136, 53, 5 Death Benefit Option/Contract Type 0 + 100 One Definition of Life Insurance Test: □ Guideline Premium Test □ Cash Value	e Accumulation Test
Renewal Premium (if applicable). \$ 136, 513 Death Benefit Option/Contract Type 174, 600 Definition of Life Insurance Test: II Guideline Premium Test III Cash Value (if available under policy applied for)	e Accumulation Test

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If more space is needed, please use the Additional Information Section, Page 13. 6 1. PAYMENT MODE (Check one) **SECTION 7 Payment** M Annual ☐ Semi-Annual Quarterly Direct Bill: Information Electronic Payment: ☐ Monthly ☐ Salary Deduction If Monthly Electronic Government Allotment Special Account: Payment is chosen, Additional Details: complete Electronic Payment Account Agreement. 2. SOURCE of CURRENT and FUTURE PAYMENTS (Check all that apply) ☐ Earned Income ☐ Mutual Fund/Brokerage Account ☐ Money Market Fund ☐ Savings ☐ Use of Values in another Life Insurance/Annuity Contract in Certificate of Deposit □ Other _ □ Loans NOTE: 3. PAYMENT It is Company rolicy to Amount collected with application \$. not accept cash, traveler's (Must equal at least one monthly premium.) checks, or money orders as a form of payment for Premium Payor: Variable Life Products. TProposed insured #1 ☐ Proposed Insured #2 ☐ Other Relationship to Proposed Insured(s) and Owner -----Reason this person is the Payor ---4. BILLING ADDRESS INFORMATION ☐ Proposed Insured #1 Address ☐ Proposed Insured #2 Address Primary Owner's Address ☐ Other Premium Payor's/Alternate Billing Address (Provide details here) Street City ___ __ State ____ Zip __ Special Arrangements E-Mail Proposed Insured #1 _____ Addresses Proposed Insured #2 (optional) Primary Owner_ Joint/Contingent Owner __

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SECTION 8 Seneral Risk	The following questions are to be answered for ALL provered by any riders applied for.	persons to be insured, including those
Questions	 Within the past three years has ANY person to be flown in a plane other than as a passenger on a sc airline or have plans for such activity within the nex IF YES, complete a separate Aviation Supplement for applicable Proposed Insured. 	theduled at year? The YES IN NO
you need more ace, please use the dditional Information ection, Page 13	2. Within the past three years has ANY person to be or intend to participate in any of the following Underwater sports - (SCUBA diving, skin diving, or Sky sports - (skydiving, hang gliding, parachuting, similar activities); Racing sports - (motorcycle, auto, motor boat or sin Rock or mountain climbing or similar activities; Bungee jumping or similar activities? IF YES, complete a separate Avocation Supplement applicable Proposed Insured.	similar activities); ballooning or imilar activities); ☐ YES Ø NO
	3. Within the next two years does ANY person to intend to travel or reside outside the U.S. or IF YES, for each occurence, please provide Proposed	Canada? IT YES 7 NO
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured U.S. Citizens? IF NO, please provide details:	Ø YES O NO
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured U.S. Citizens? IF NO, please provide details: Proposed insured(s) Count	Ø YES∩ NO
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured U.S. Citizens? IF NO, please provide details:	Ø YES ∩ NO ry of Citizenship
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured U.S. Citizens? IF NO, please provide details: Proposed insured(s) Count Visa Type/ID Visa N	Try of Citizenship
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured U.S. Citizens? IF NO, please provide details: Proposed insured(s) Count Visa Type/ID Visa N Expiration Date Length	Ø YES □ NO Try of Citizenship The definition of Time in U.S Try number.
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured U.S. Citizens? IF NO, please provide details: Proposed insured(s)	Ty of Citizenship
	4. CITIZENSHIP/RESIDENCY A. Are all persons to be insured U.S. Citizens? IF NO, please provide details: Proposed insured(s)	Ty of Citizenship

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	If more space is needed, please use the Additional Information Section The following questions are to be answered for ALL persons to be insured, in	icluding those
SECTION 8	covered by any riders applied for.	
General Risk Questions continued)	chew; etc.) or nicotine substitutes (e.g., paro i, gorin:	□ YES Ø NO
	Proposed Insured(s) Date Last Used	
	Туре	
	Amount/Frequency	
If you need more space, please use the Additional Information Section, Page 13.	6. Has ANY person to be insured: EVER had a driver's license suspended or revoked, EVER been convicted of DUI or DWI; or had, in the last five years, any moving violations? IF YES, please provide Proposed Insured, date and violation. Proposed Insured(s)	☐ YES Ø NO
	Proposed insured(s) Details:	
	Details:	
	7. Has any person to be insured EVER had an application for life, disability income or health insurance declined, postponed, rated or modified or required an extra premium? IF YES, please provide details:	☐ YES Ø NO
	Proposed Insured(s)	
	Details:	
	8. Are all persons to be insured: actively at work; or a homemaker performing regular household duties; or a student attending school regularly? IF NO, please provide details:	Ø YES (7 NO
	Proposed Insured(s)	
	Details:	
Please answer these	9. LONG TERM CARE GUARANTEED PURCHASE OPTION RIDER	
questions only if requesting the Long Term Care	A. Does any person to be insured under this rider currently use any mechanical equipment such as: a walker; a wheelchair; long leg braces;	☐ YES ☐ NO
Guaranteed Purchas Option Rider.	or crutches? IF YES, please note which and the reason.	
	Proposed Insured(s)	
	B. Does any person to be insured under this rider need any assistance or supervision with any of the following activities: bathing; dressing; walking moving in/out of a chair or bed; tolleting; continence; or taking medication?	ng; (1 YES (1 NO
	Proposed Insured(s)	

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PART II	If more space is needed, please use the Addit	ional Information Section, Page 13.		
SECTION 1 Physician Information	1. PHYSICIAN Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up to date information concerning the present health of the Proposed Insured(s).			
	Physician Information for Proposed Insur Check here if no doctor, practitioner or health:	red #1 care facility is known.		
PLEASE NOTE:	Physician Name Slomowits Joseph Md	Phone Number (718) 851-8400		
If FULL PARAMEDICAL	Name of Practice/Clinic	Fax Number ()		
exam is required, completion of Medical	Street 5022 15 Ave			
questions is OPTIONAL but will expedite	City Brooklyn	State NY Zip 11219		
your application	Date Last Consulted Reason _			
	Findings, treatment given, medication prescribed.			
	Physician information 🏻 Proposed insu	red #1 ☐ Proposed Insured #2		
	☐ Check here if no doctor, practitioner or health	care facility is known.		
	Physician Name			
	Name of Practice/Clinic	Fax Number ()		
	Street			
	City			
	Date Last Consulted Reason _			
	Findings, treatment given, medication prescribed.	. If None, check here □.		
SECTION 2	1. HEIGHT/WEIGHT			
Medical	Proposed Insured #1 Height	Weight		
Questions	1	Weight		
	· ·	-		
	Has any Proposed Insured experienced a change (greater than 10 pounds) in the past 12 months?	in weight O YES (1 NO		
		DIESERO		
	IF YES, specify: Proposed Insured #1 Pounds lost	Pounds asinod		
	1			
		Pounds gained		
	Reason	***************************************		

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SECTION 2 Medical Questions (conunued)	coronary arter	P) or sibling (S) of a y disease; high bloc	かい かみばんか									
Questions	IF YES, indicate		od pressure	to be insue; diabetes	t or wer	tal illness? \Box	sease; YES (7)	NO				
(continued)		IF YES, indicate below:										
	Proposed instred (#1, #2)	Relationship to Proposed Insured	Age if Living	Age at Death		State of Hei Specific Cond Cause of De	itians,					
PLEASE NOTE: If FULL PARAMEDICAL		⊐p <u>.</u> ⊐s										
exam is required, completion of Medical		op Js										
questions is OPTIONAL		១៦ ១១										
but will expedite your application.		១៦ ១៩		<u> </u>								
	A. High blood p	ressure chest pain:	heart									
	ļ			YE	S NO	YES NO	YES					
	attack, or an	v other disease or d	lisorder of		, es			_				
	attack, or an the heart or	y other disease or di circulatory system?	lisorder of	a	ø	0 0	o	a				
	attack, or an the heart or B. Asthma; broi shortness of	y other disease or d circulatory system? nchitis; emphysema, breath; or any othe	lisorder of ; sleep apr r disease (anea; Or								
	attack, or an the heart or B. Asthma; broi shortness of	y other disease or d circulatory system? nchitis; emphysema	lisorder of ; sleep apr r disease (anea; Or		00	0 0	0				
	attack, or an the heart or B. Asthma; broishortness of disorder of the control o	y other disease or di circulatory system? nichitis; emphysema, breath; or any othe nie lungs or respirato ike; paralysis; Alzhe	isorder of ; sleep apr r disease (ory system imer's dise	nea; or i? ====================================								
	attack, or an the heart or B. Asthma; broi shortness of disorder of the C. Seizures; stroid multiple scledisease; productions attacks of the control of the	y other disease or di circulatory system? inchitis; emphysema, breath; or any othe ne lungs or respirate like; paralysis; Alzhe rosis; memory loss; pressive neurologica	; sleep apr r disease (ory system imer's dise Parkinson' I disorder;	nea; or :? ====================================								
	attack, or an the heart or the heart or shortness of disorder of the control of t	y other disease or di circulatory system? inchitis; emphysema, breath; or any other he lungs or respirate like; paralysis; Alzhe crosis; memory loss; gressive neurologica or any other disease	; sleep apr r disease o ory system imer's dise Parkinson' I disorder; or disordi	nea; or :? ====================================								
	attack, or an the heart or the heart or shortness of disorder of the control of t	y other disease or di circulatory system? inchitis; emphysema, breath; or any othe ne lungs or respirate like; paralysis; Alzhe rosis; memory loss; pressive neurologica	; sleep apr r disease o ory system imer's dise Parkinson' I disorder; or disordi	nea; or ?? == rase; s		0 0	0	0				
etails: If you answered	attack, or an the heart or shortness of disorder of the C. Seizures; strong multiple scledisease; progheadaches; of the brain	y other disease or discretiatory system? inchitis; emphysema, breath; or any other lungs or respirate lungs or respirate lungs; Alzhe rosis; memory loss; pressive neurologica or any other disease or nervous system?	; sleep apr r disease (ory system imer's dise Parkinson' I disorder; or disord	nea; or ? or ease; s er		0 0	0	0				

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If more snace is needed	i, please use the Additional Information Section, Page 13	. 11
If their about in the series		

SECTION 2 Medical Questions

(continued)

PLEASE NOTE:
If FULL PARAMEDICAL
exam is required,
completion of Medical
questions is OPTIONAL
but will expedite
your application

3. Has ANY person to be insured EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that ne/she had:

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	Propo		Proposed Insured #2		Oth Propo Insu	sed
	YES	NO	YES	NO	YES	NO
D. Ukers: colltis; hepatitis, cirrhosis; or any other disease or disorder of the liver; gallbladder; stomach, or intestines?	ä	n	n	a l	n	ជ
E. Any disease or disorder of: the kidney; bladder; or prostate; or blood, protein or pus in the urine?	0	a	٥	D D	a	a
F. Diabetes; thyroid disorder; or any other endocrine problem(s)?	o	a	a	o	G	G
G. Arthritis; gout; or disorder of the muscles, bones or joints?	ß	0	a	0	D	٥
H. Cancer; tumor; polyp; cyst or any skin disease or disorder?	o	o o	O	o .	0	ø
Anemia; leukemia; or any other disorder of the blood or lymph glands?	ø	n	រា	a	a	۵
3. Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	O	۵	٥	o	0	o
K. Any disease or disorder of the eyes, ears, nose, or throat?	0	a	0	a	o	o

Details: If you answered YES to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Name of Physician Address If not already provided	Date/Duration of liness	Diagnosis/Severity Medications/Treatment
			<u> </u>	

ridokiza i inizorli uziseli mido drali midoli nizoli nidomine ino domizo fiministi ni marizo il mimo il o morta

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SECTION 2	4. Has ANY person to be insured:	Prop	osed	Propo	sed	Ouh	er
Medical		Insur		Insure		Proposed	
Questions		YES	NO	YES	NO	YES	
(continued)	A. Currently, or within the past six months, been under observation or received treatment or taken any medication? (including over-the-counter medications, vitamins, herbal supplements, etc.)	0	ני	0	ם	ם	a
PLEASE NOTE:	B. For the next six months, scheduled any doctor's visits, medical care, or surgery?	n	n	C	a	n	a
If FULL PARAMEDICAL exam is required, completion of Medical	C. During the past five years, had at checkup; electrocardiogram; chest x-ray; or medical test?	b	o	ם	o	0	
questions is OPTIONAL but will expedite your application.	D. During the past five years, had any illness, injury or health condition not revealed above; or have been recommended to have any: hospitalization; surgery; medical test; or medication?	ភ		0	0	0	٥
	E. EVER been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	0	G		a	a	٥
	F. EVER used heroin, cocaine, barbituates, or other drugs, except as prescribed by a physician or other licensed practitioner?	3	a	0	O	0	C
	G. EVER received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs, except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	o	o	0	a		ė
	an acondi or drug prometri:	.,	₩.				_
	arraiconds or drag problem:						

Details; If you answered YE5 to any of the above questions, please provide details here.

Question Number Proposed Insured Address If not already provided Of Illness Medications/Treatment

Date/Duration of Illness Medications/Treatment

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Additional Information	Use this page for any additional information. Attach a separate sheet if necessary.

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Certification/ Agreement/ Disclosure					
Agent certifies that a signed illustration is not An illustration was signed and matches the An illustration was shown or provided but is to the policy as issued will be provided no lail No illustration conforming to the policy as illustration conforming to the policy illustration conforming to the lift illustration was only shown on a comp	t required by la e policy applied different from ter than at the tin illey as applied for policy as issued w	w or the policy ap of for. It is include the policy ap; ne of policy delive or was shown or p will be provided no	plied for is not is ed with this app plied for. An is ry. rovided prior to later than at the	Ilustrated i dication. dustration o	conforming
An illustration was displayed on a computer but no printed copy of the illustration was provided no later than at the time of policy cand policy information:	screen. The display	ayed illustration m	atches the p	issued will	be
 Gender (as illustrated) Rating class (e.g. standard, smoker) 		☐ Unisex ☐ Standard		er 🗆 S	
3 Type of policy (e.g. L-98, Whole Life) 4. Initial Death Benefit \$	Death	Benefit Option			
5. Guaranteed Minimum Death Benefit	_	'Ɗ age 65 €	7 age 75 🖂	age 85	C) 5 years
6. Dividend Option					
7. Riders					
Agreement/Disclosure I have read this application for life insurance knowledge and belief, all statements are true My statements in this application and any amendme This application and any: amendment(s); paramedica become part of the new policy. No information will be deemed to have been given than any supplement(s). Only the Company's President, Secretary or Vice-President promise about insurance; or (c) change or waive any Except as stated in the Temporary Insurance Agreement	e and complete, Int(s), paramedical/mid/medical exam; and to the Company undersident may: (a) make term of an application	l also agree that: edical exam and sup supplement(s) to this ss it is stated in this or change any contri on, receipt, or policy,	plement(s) are the sapplication, will lapplication and pa act of insurance; (b	basis of any pe attached iramedical/m	policy issued. to end edical exam, ading

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Certification/ Agreement/ Disclosure

(continued)

- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or
- If I intend to replace existing insurance or annuities, I have so indicated in Section 2, Question 2 of this application.
- I have received the Company's Consumer Privacy Notice and, as required, the Life Insurance Buyer's Guide. . If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.
- I understand that receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount is associated with the acceleration and an administrative charing will be required upon exercise of the benefit.

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that: The number shown in this application is my correct taxpayer identification number, and I am not subject to

(a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all

(b) the IRS has notified me that I am not subject to backup withholding. (If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)

I am a U.S. citizen or a U.S. resident alien for tax purposes.

(If you are not a U.S. citizen or a U.S. resident alien for tax purposes, please cross out this certification and complete

Please note: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

SIGNATUR	ES:	Signed at City, State Brewklyn NY Date 12/17/07 Proposed Insured #1 Halla Salarleour [age 15 or over]
If not witnessing all signatures.		Proposed Insured #1 Kalla Salend
Witness should sign next to the signature being witnessed.		Signed at City, State
• • • • • • • • • • • • • • • • • • • •		(age 15 or over)
		Signed at City, State Date
		(If other than Proposed Insured) (If age 15 or over) If the Owner is a firm or corporation, include Officer's title with signature.
		Signed at City, State Date
		Parent or Guardian (If Owner or Proposed Insured(s) is/are under 18, sign here if not signed above.)
		Signed at City, State Brooklyx NY Date 12/17/07
		Witness to Signatures Athle (Licensed Agent/Producer)
		Please print Agent/Producer name Mayer Kramarsky

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	Check the appropriate co		
	Proposed Insured: Ha		Salamon
Personal Financial		insurance Company	
Supplement	☐ MetLife Investors		☐ Metropolitan Tower Life Insurance Compan
	The Co.	mpany indicated above	is referred to as "the Company".
To be completed when	INCOME		
the amount of coverage	Annual Earned Inco	me	
is \$1,000,000 and over.	Salary or Draw	100,000.00	
	Bonus/Comayssions	\$	-
	Other Earnings	\$	
	Total Earned Income	140 000 00	
	Spouse's Income	\$	-
	Annual Unearned In	come	
	Dividends/Interest	\$ 50,000.00	
	Net Rentals	5	_
	Other Unearned	\$	Source
	Total Uncarned Incom	\$ 50,000.00	
	ASSETS & LIABILIT	TES	
	Assets	•	Liabilities
	Cash	\$	Mortgages \$
	Real Estate	\$	Personal Loans \$
	Business Equity	\$	Other \$
	Stocks/Bonds	\$	~_
	Other Assets	s <u>10,000,000.00</u>	
	Total Assets	s <u>10,000,000.80</u>	Total Liabilities \$
•		Total Assets	10,000,000.00
	1	Total Liabilities -	5 0.00
		at a shim make	<u> </u>
		Net Worth: =	- MANANANANA
	1		

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Stephen Mostecak
Principal Investigator
Fraud Investigation Division

AIG World Investigative Resources Northeast Region

P.O. Box 372 West Nyack, NY 10994 845.398.0675 - Phone 917.862.2862 - Cell 1.866.667.8514 - (E-fax)

August 6, 2008

Mr. Joel Katz
750 Forest Avenue
Apartment 25D
Lakewood, NJ 08701

Re: Hana Salamon Policy # U10022254L - AIG American General

Mr. Katz:

I am an Investigator for AIG (American Interntional Group)

Stephen Mostecak Principal Investigator

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Hana Salamon Accurint Search w/ SSN of 319.82.9296

Important: The Public Records and commercially available data sources used on reports have errors. Data is sometimes entered poorly, processed incorrectly and is generally not free from defect. This system should not be relied upon as definitively accurate. Before relying on any data this system supplies, it should be independently verified. For Secretary of State documents, the following data is for information purposes only and is not an official record. Certified copies may be obtained from that individual state's Department of State.

Summary Report

Date: 01/23/08

Reference Code: 20080293

Subject Information

AKAS (Names Associated with Subject)

Indicators

Name: HANA SALAMON

Age:

SSN: 090-30-5929 issued in New York between 01/01/1954 and

12/31/1957

[No Data Available]

Bankruptcy: No Property: No Corporate Affiliations: No

Others Associated with SSN: (DOES NOT usually indicate any type of fraud or deception) MARTIN SALAMON DOB: 12/1915 Age: 92

Address Summary (- Probable Current Address)

√ 4910 17TH AVE APT 2J, BROOKLYN NY 11204-1185, KINGS COUNTY (Jun 2003 - Jan 2008)

Phone at address: (718) 851-9250 SALAMON MR

Neighborhood Profile (2000 Census)

Average Age: 34 Median Household Income: \$30,341 Median Home Value: \$667,800 Average Years of

Education: 12

√ 4910 17TH AVE APT 2Z, BROOKLYN NY 11204-1157, KINGS COUNTY (Jun 2003 - May 2007)

Phone at address: (718) 851-9250 SALAMON MR

Neighborhood Profile (2000 Census)

Average Age: 34 Median Household Income: \$30,341 Median Home Value: \$667,800 Average Years of

Education: 12

√ 4910 17TH AVE APT 4G, BROOKLYN NY 11204-1187, KINGS COUNTY (Oct. 1990 - Nov. 2006)

Phone at address: (718) 851-9250 SALAMON MR

Neighborhood Profile (2000 Census)

Average Age: 34 Median Household Income: \$30,341 Median Home Value: \$667,800 Average Years of

Education: 12

4141 COLLINS AVE APT 109, MIAMI BEACH FL 33140-3238, MIAMI-DADE COUNTY (Feb. 2005)

Neighborhood Profile (2000 Census)

Average Age: 42 Median Household Income: \$38,214 Median Home Value: \$367,900 Average Years of

Education: 14

1 1 1



Stephen Mostecak Principal Investigator

Fraud Investigation Division

AIG World Investigative Resources Northeast Region

P.O. Box 372 West Nyack, NY 10994 Phone: 845.398.0675

Cell: 917.862.2862 Fax: 1.866.667.8514

August 7, 2008

Mr. Aaron Knopfler 750 Forest Avenue Lakewood, NJ 08701

Re: Life Policy of Hana Salamon - # U10022254L - AIG American General - Issued 12/'07

Mr. Knopfler:

You, as well as Joel Katz, are listed on the above policy of our insured, Hana Salamon. As part of our business practice, I am required to meet with you in person to discuss the Trust aspects of the policy set-up.

As such, kindly call me upon receipt of this letter at the above phone number so that we can schedule an appointment that is convenient for you.

Thank you very much and I anticipate an expedient response, sir.

Stephen Mostecak Principal Investigator

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Office of the City Register

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About ACRIS
About City Register
Contents (Contents)

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Current Search Criteria:

Borough: BROOKLYN

/ KINGS
Block: 05454
Lot: 0045
Date Range: To
Current Date

Document Class: All Document Classes

√iew	Reel/Pg/File	CRFN	Lot	Partial	Recorded / Filed	Document Type	Pages	s Party1	Party2	Party More 3/ Party Corrected Other 1/2 Remarks	-
	20	0700041690	1 45		8/13/2007 12:38:59 PM	UCC3 ASSIGNMENT	4	UNGAR, JACOB	FIRST FINANCIAL EQUITIES, INC.	Names	
	20	0700027504	6 45			UCC3 TERMINATION	3	LICHT, SIMON	HSBC MORTGAGE CORPORATION (USA)		
	20	0700026668	0 45		5/22/2007 2:48:34 PM	BOTH RPTT AND RETT	1	SOUTHBERRY ENTERPRISES LLC	WEINGARTEN, DAVID		132,
	20	0700026667	5 45		5/22/2007 2:48:11 PM		1		WEINGARTEN, DAVID		132,
	20	0700023265	4 45	ENTIRE LOT	5/4/2007 10:32:34 AM	UCC3 AMENDMENT	3	SOUTHBERRY ENTERPRISES, LLC	HERCZL, ARON		
	200	0700013911	6 45	ENTIRE LOT	3/15/2007 11:44:16 AM	INITIAL COOP UCC1	3	LICHT, SIMON	HSBC MORTGAGE CORPORATION USA		
	200	07000100069	9 45	ENTIRE LOT	2/22/2007 11:35:12 AM	BOTH RPTT AND RETT	2	RINGEL, HARRY	BRONNER, CHASKEL		325,
	200	07000100068	8 45	ENTIRE LOT	2/22/2007 11:35:11 AM	POWER OF ATTORNEY	4	RINGEL, MURIEL	MILLER, DEBRA		

0067 45 ENTIRE 2, LOT 1	22/2007 POWER OF 1:35:10 ATTORNEY AM	4	RINGEL, HARRY	MILLER, DEBRA	
4582 45 ENTIRE 9, LOT 3:		2	HOOK, SIMEON	BUCHMAN, HEDY	310,
	/5/2006 INITIAL COOP 05:02 PM UCC1	3	LICHT, SIMON	HSBC MORTGAGE CORPORATION (USA)	
1398 45 ENTIRE 6, LOT 3:	30/2006 UCC 09:57 PM COOPERATIVE ADDENDUM	3	UNGAR, JACOB	INMC MORTGAGE HOLDINGS	
7434 45 ENTIRE 6, LOT 1	15/2006 UCC 2:02:03 COOPERATIVE PM ADDENDUM		WEINBERGER, SIMA	CALIFORNIA FEDERAL BANK, A FEDERAL SAVINGS BANK	
	13/2006 BOTH RPTT 2:35:40 AND RETT	1	BERGER, MARK	APPEL, EVA	300,
3842 45 ENTIRE 4,	PM (27/2006 INITIAL COOP 47:33 AM UCC1	9 4	LICHT, BELA	M & T MORTGAGE CORPORATION	
1332 45 PARTIAL 2	/7/2006 INITIAL UCC1 0:48:17	. 3	SOUTHBERRY ENTERPRISES,	HERCZL, ARON	
	AM /20/2005 BOTH RPTT 41:46 PM AND RETT	1	LLC ELDIN REALTY COMPANY	SOUTHBERRY ENTERPRISES, LLC	140,
	/19/2005 BOTH RPTT 02:00 PM AND RETT	1	ELDIN REALTY COMPANY	SOUTHBERRY ENTERPRISES	140,
5702 45 ENTIRE 9 LOT 4:	/9/2005 UCC3 35:03 PM TERMINATION		HOSCHANDER, MIRIAM	JPMORGAN CHASE BANK	
	11/2005 INITIAL COOP 55:59 PM UCC1	3	HOSCHANDER, MIRIAM	JPMORGAN CHASE BANK, N.A.	
7557 45 ENTIRE 3 LOT 3:	/3/2005 UCC3 09:24 PM ASSIGNMENT	. 3	FISCH, ELKY	EVERBANK	
5495 45 PARTIAL 1: LOT 2:	2/2/2004 UCC3 09:29 PM ASSIGNMENT	. 3	STIEL, FISCHEL	FLEET NATIONAL BANK	
4501 45 ENTIRE 8, LOT 2:	13/2004 NYC REAL 20:27 PM PROPERTY TRANSFER TAX	2	HERTZ D/B/A/, SHELDON	GEIGER, SAUL	100,
4492 45 ENTIRE 8/ LOT 2:		2	HERTZ D/B/A, SHELDON	GEIGER, SAUL	200,
1943 45 ENTIRE 3/ LOT 3:	22/2004 INITIAL UCC1	4	4910 17TH AVE. APT. CORP.	NEW YORK COMMUNITY BANK	
1942 45 ENTIRE 3/ LOT 3:	22/2004 AGREEMENT 22:11 PM	14		4910 17TH AVE. APT. CORP.	1,200,
1941 45 ENTIRE 3/ LOT 3::		9	4910 17TH AVE. APT.	NEW YORK COMMUNITY BANK	1,200,
	22/2004 ASSIGNMENT, 22:09 PM MORTGAGE	7	CORP. J.P. MORGAN INVESTMENT MANAGEMENT, INC.	NEW YORK COMMUNITY BANK	
	22/2004 TERMINATION 2:08 PM OF ASSIGN OF		4910 17TH AVE. APT.	J.P. MORGAN INVESTMENT	
	L&R 28/2004 INITIAL COOP 1:06:43 UCC1	2	CORP. LICHT, SIMON	MANAGEMENT, INC. WELLS FARGO HOME MORTGAGE, INC.	
5786 45 ENTIRE 10, LOT 9:5	AM 17/2003 UCC3 9:24 AM TERMINATION	4	STIEL, CHAIM Y	MORTGAGE ELECTRONIC	

							REGISTRATION	
	2003000406789 4	5 ENTIRE LOT	10/2/200 9:44:19 A	3 INITIAL COOP M UCC1	3	HOSCHANDER MIRIAM	SYSTEM , JP MORGAN CHASE BANK	
	2003000159071 45	5 ENTIRE LOT	6/6/2003 11:09:00 A M		3	STIEL, FISCHEL	FLEET NATIONAL BANK	
	2003000130468 45				4	SURI, ELIAS	WASHINGTON MUTUTAL BANK, FA	
	2003000000345 45		1/9/2003 4:46:39 PI		3	FISCH, ELKY	BNY MORTGAGE COMPANY, LLC	
02PK09915		ENTIRE LOT	11/21/200	2 UCC3 AMENDMENT	1	WELZ, ALEXANDER	BNY MORTGAGE COMPANY, LLC	
5638/1990	45	ENTIRE LOT	5/24/2002	2 DEED	4	LANDAU, BERTA	B LANDAU FAMILY TRUST	
02PK01648	45	ENTIRE LOT	3/6/2002	INITIAL COOP UCC1	2	WELZ, ALEXANDER	BNY MORTGAGE COMPANY, LLC	
01PK04969	45	ENTIRE LOT	4/11/2001	UCC3 ASSIGNMENT	1	STIEL, CHAIM Y.	BNY MORTGAGE COMPANY, L.L.C.	
01PK04321	45	ENTIRE LOT	3/29/2001	. INITIAL COOP UCC1	2	STIEL, CHAIM Y.	BNY MORTGAGE COMPANY, L.L.C.	
01TK00911	45	ENTIRE LOT	3/27/2001	UCC3 TERMINATION	1	BRACHFELD, MONIQUE	INDEPENDENT NATIONALMORTGAGE	
01PK04144	45	ENTIRE LOT	3/27/2001	UCC3 ASSIGNMENT	1	BRACHFELD, MONIQUE	CORPORATION GFI MORTGAGE BANKERS, INC.	
01PK03940	45	ENTIRE LOT	3/22/2001	INITIAL COOP UCC1	1		CHASE MANHATTEN BANK	
97PK10030	45	ENTIRE LOT	7/31/1997	UCC3 ASSIGNMENT	1	UNGAR, JACOB	FIRST FINANCIAL EQUITIES INC	
97PK09917	45	ENTIRE LOT	7/29/1997	INITIAL COOP UCC1	1	UNGAR, JACOB	FIRST FINANCIAL EQUITIES INC	
97PK03573	45	ENTIRE LOT	3/20/1997	INITIAL COOP UCC1	2	BRACHFELD, MONIQUE	GFI MORTGAGE BANKERS, INC.	
96PK16881	45	ENTIRE LOT	12/26/1996	UCC3 RELEASE	6	HOSCHANDER, DAVID	MONOGRAM HOME EQUITYCORP	
96PK16880	45	ENTIRE LOT	12/26/1996	UCC3 RELEASE	9	HOSCHANDER, DAVID	MONOGRAM HOME EQUITYCORP	
94PK04908	45	ENTIRE LOT	4/8/1994	UCC3 ASSIGNMENT	1	HOSCHANDER, DAVID	GE CAPITAL MORTGAGESERVICE	
94PK04907	45	ENTIRE LOT	4/8/1994	UCC3 ASSIGNMENT	1	HOSCHANDER, DAVID	INC GE CAPITAL MORTGAGESERVICES	
94PK04822	45	ENTIRE LOT	4/6/1994	INITIAL COOP UCC1	1	HOSCHANDER,	INC GE CAPITAL MORTGAGESERVICE	
94PK04821	45	ENTIRE LOT	4/6/1994	INITIAL COOP	4	HOSCHANDER,	INC GE CAPITAL MORTGAGESERVICES	
3222/900	45	ENTIRE LOT	2/22/1994	SATISFACTION OF MORTGAGE	2	HERTZ,	INC KRAVCHICK, MAE	
3222/729	45			ASSIGNMENT, MORTGAGE	3	SHELDON HERTZ,	J.P. MORGAN	
3222/724	45		2/22/1994	MORTGAGE	5	SHELDON 4910 17TH AVE APT CORP	INVESTMENT MANAGEMENT INC J.P. MORGAN INVESTMENT MANAGEMENT INC	329

 3222/411	4E FAITY	DE 2/22/102					
	LOT	Γ	ASSIGNMENT, MORTGAGE	9	4910 17TH AVE APT. CORP.	J.P. MORGAN INVESTMENT MANAGEMENT INC	
3222/377	45 ENTI		AGREEMENT	36		J.P. MORGAN INVESTMENT	
3222/368	45 ENTII LOT		ASSIGNMENT, MORTGAGE	9	GREEN POINT SAVINGSBANK	INVESTMENT	
94PK01664	45 ENTII LOT		INITIAL UCC1	4	4910 17TH AVE APT CORF		
93TK02024	45 ENTII LOT	RE 8/30/1993	UCC3 TERMINATION	2	LANDAU, BERTA	MANAGEMENT INC CITIBANK, NA	
 93PK01980	45 ENTII		INITIAL COOP	1	LANDAU, BERTA	INDEPENDENCE SAVINGSBANK	
92PK14075	45 ENTII LOT		INITIAL COOP UCC1	1	BOORSTEIN, MYRON RONALD	MARINE MIDLAND BANK	
2670/1012	45 ENTII LOT		ASSIGNMENT, MORTGAGE	5	HERTZ, HENRY	HERTZ, SHELDON	
89PK00667	45 ENTIF LOT	RE 1/17/1989	INITIAL UCC1	2	LANDAU, BERTA	CITIBANK, NA	
8901/667	45 ENTIF LOT	RE 1/17/1989	UNIFORM COMMERCIAL CODE 1	0	LANDAU, BERTA	CITIBANK NA	
2035/2121	45 ENTIF LOT		ASSIGNMENT, MORTGAGE	2	KRAVCHICK, HYMAN/LWT	ELDIN REALTY CO	
1845/519	45 ENTIF LOT		ASSIGNMENT, MORTGAGE	4	HERTZ, SHELDON	HERTZ, HENRY	
1845/514	45 ENTIF LOT		ASSIGNMENT, MORTGAGE	5	ELDIN RLTY COMP	HERTZ, HENRY	
1797/1500	45 ENTIF LOT	RE 4/17/1986	MORTGAGE	10	4910 17TH AVE APT CORP	ELDIN RLTY CO	800
1797/1498	45 ENTIR LOT	RE 4/17/1986	DEED	2	ELDIN RLTY CO	4910 17TH AVE APT.CORP	
1327/1186	LOT		DEED	2	HERTZ, SHELDON	ELDIN REALTY COMPANY	
1325/1053	45 ENTIR LOT	E 7/9/1982	MORTGAGE	5	HERTZ, SHELDON	KRAVCHICK, HYMAN DECD	300
1325/1051	LOT	E 7/9/1982	DEED	2	KRAVCHICK, HYMAN DECD	HERTZ, SHELDON	
918/523	45 ENTIR LOT	E 5/5/1977	DEED	2	RAYTY REALTY CORP	MITGAG SHIRLEY	
918/15	45 ENTIR LOT	E 5/4/1977	SUNDRY AGREEMENT	5	THE GREEN POINT SAV		
918/12	45 ENTIR LOT	E 5/4/1977	ASSIGNMENT, MORTGAGE	3	BANK DOLLAR SAVINGS BANK OF NEW YORK	THE GREEN POINT SAV BANK	
918/7	LOT	E 5/4/1977	MORTGAGE	5		THE GREEN POINT SAVINGS BANK	
918/5	45 ENTIRI LOT	5/4/1977	DEED	2	SHIRLEY AS	RAYTY REALTY CORP	
569/261	45 ENTIRE LOT	7/14/1972	SUNDRY AGREEMENT	13	TRUSTEE OF RUTCO RLTY CORP		

534/735	45 ENTIRE 1/25/1972 LOT	DEED	2	RUTCO REALTY CORP	MITGANG SHIRLEY AS TRUSTEE OF
533/1950	45 ENTIRE 1/24/1972 LOT	AGREEMENT	4	RUTCO REALTY CORP	DOLLAR SAVINGS BANK
533/1945	45 ENTIRE 1/24/1972 LOT	MORTGAGE	5	RUTCO REALTY CORP	DOLLAR SAVS BANK OF NYC
533/1941	45 ENTIRE 1/24/1972 LOT	ASSIGNMENT, MORTGAGE	2	HARLEM SAVS BANK	DOLLAR SAVS BANK
532/1521	45 ENTIRE 1/18/1972 LOT	DEED	2	MITGANG SHIRLEY TRUSTEE OF	RUTCO REALTY CORP
463/1492	45 ENTIRE 2/5/1971 LOT	DEED	2	RUTCO RLTY CORP	MITGANG SHIRLEY AS TRUSTEE OF
459/1049	45 ENTIRE 1/19/1971 LOT	DEED	2	MITGANG SHIRLEY AS TRUSTEE OF	RUTCO RLTY CORP

New Parcel Identifier Search

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Hana Salamon Page 1 of 2

From: Mostecak, Stephen

Sent: Thursday, July 17, 2008 3:36 PM

To: 'Pinchas Geller, CPA' Subject: RE: Hana Salamon

Dear Mr. Geller:

As you are aware, I am conducting an investigation regarding an American General life insurance policy insuring the life of one of your clients, Hana Salamon. As part of my investigation, I have contacted you numerous times (once in an in-person interview) in an attempt to solicit information from you to confirm the accuracy of financial representations in Ms. Salamon's life insurance application. However, rather than provide information to verify Ms. Salamon's representations in her life insurance application, you have refused to cooperate with the investigation. If you have information that can establish the accuracy of the financial representations in Ms. Salamon's application, please provide it by Friday, July 18, 2008. If we do not receive information from you by July 18th, we will assume that no such information exists.

Stephen J. Mostecak

Principal Investigator

AIG World Investigative Resources (AIGWIR)

Fraud Investigation Division

P.O. Box 372

West Nyack, NY 10994

Office: 845.398.0675; E-Fax: 1.866.667.8514

Cell: 917.862.2862

E/Mail: Stephen.Mostecak@AlG.com

F.I.D. Intranet Site: http://aignetprod.aig.com/cffid

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From: Pinchas Geller, CPA [mailto:pinnygcpa@gmail.com]

Sent: Thursday, July 17, 2008 10:18 AM

To: Mostecak, Stephen **Subject:** RE: Hana Salamon

Mr. Mostecak

I would very much want to assist you in your investigation, however, I determined that me talking to you would be in violation of IRC and AICPA code of professional standards. I reviewed the Internal Revenue Code and the AICPA code of professional standards. According to IRC Section 7216 and AICPA rule 301 I can't disclose any information of my clients without their specific consent. Violation of IRC 7216 is subject to a fine or imprisonment or both.

Respectfully, Pinchas Geller, CPA

From: Mostecak, Stephen [mailto:Stephen.Mostecak@AIG.com]

Sent: Wednesday, July 16, 2008 4:39 PM

To: 'PGeller@PGellerCPA.com' **Subject:** Hana Salamon

Hana Salamon Page 2 of 2

Mr. Geller:

Thanks for taking the time and meeting with me today regarding my investigation of the life policy issuance of Hana Salamon.

Kindly contact me as soon as possible once you locate your file on Hana Salamon that depicts her real estate property ownership that you verified to the investigator from Infolink Services, John Vega, and which AIG American General based the issuance of the policy on.

Thanks very much.

Stephen J. Mostecak

Principal Investigator
AIG World Investigative Resources (AIGWIR)
Fraud Investigation Division
P.O. Box 372

Office: 845.398.0675; E-Fax: 1.866.667.8514

Cell: 917.862.2862

West Nyack, NY 10994

E/Mail: Stephen.Mostecak@AlG.com

F.I.D. Intranet Site: http://aignetprod.aig.com/cffid

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Note to AIGWIR Files:

20080289 Moses Feder 20080290 Agi Fliegman 20080291 Alvin Lapides 20080292 Lola Lieber-Schwartz 20080293 Hana Salamon

1/22/2008:

S/W Jim Bilello of MetLife who made inquiries as to existing or applied for coverage of the above 5 individuals.

I advised him that I did not show any EXISTING coverage with the exception of Hana Salamon, policy # U10022254L, for \$8.5M. Note that the SSN used by Hana Salamon for MetLife is 319.82.9296 and that Mr. Bilello's Acurint search reveals an SSN for her as 090.30.5929. It should further be noted that the last 4 SSN digits on AIG's policy for Hana Salamon is 9295. MetLife has NOT YET issued on Hana Salamon.

I sent inquiries to Mary Cummings of AIGWIR to determine if any applied for coverage existed and if so to obtain the policy applications.

Jim Bilello advised that the Agents on his policies were MAYER KRAMARSKY and LAZER LEVI. Our Agent on the Salamon policy is Halpert Yitzchok.

Mr. Bilello advised that he knows that Moses Feder did apply (application signed) on 12/9/07 to American General for 10M.

Hana Salamon's application was signed on 12/17/2007, which is post AIG's application date of 12/13/2007. AIG issued on 12/28/2007 on Ms. Salamon.

Mr. Bilello advised that the Brokerage/Broker for his 5 proposed insureds, Lifemark, applied for \$10M for each of the five and asked if MetLife could waive the stress tests of the 5 insureds, which was denied. The Broker then came back and said, in essence, "OK, we'll apply for \$5M on each.

MetLife advised that in an attempt to verify income and net worth, the insured, Hana Salamon, advised that her income is \$100K a year, as well as \$50K of unearned income and that she had a Net Worth of \$10M. She said that she is a self-employed ARTIST.

I have asked AG (via Ofelia Gonzales) for a copy of the complete policy file on Hana Salamon, and I have asked AIGWIR's Mary Cummings to check on all APPLIED FPR coverage on all 5 people.

The 5 named individuals from MetLife appear at the end of this document, as is the Policy Summary Page.

Investigation to continue and I will notify Sr. Counsel Katherine Easterby of the MetLife request.

Jan 22 38 01:44p

Stephen Mosterex

845-308-0675

p.1

Page 1 of 6 restived at 12202008 11 25/49 JAK Essiem Standurd The Stones AS-Cuttof Accounted

MetLife Insurance

To: Steve Mostecak
Company: AIG
Date: January 22, 2008
From: Jim Bilello
Fax Number: (908) 655-9901
Business Number: (732) 326-5138
E-Mail jbilello@mattife.com

Steve.

MetLife is reviewing the underwriting for a recently applied and/or issued policy to determine whether undisclosed coverage may have existed at the time of issue. Our records indicate that this application may have been slupped for competitive premium bids and that AIG may have received an application. Please advise whether AIG has issued on the following individual and, if so, please provide the face amount, date of issue and agent of record:

Policy Number	First Name	Last Name	<u>\$\$⊭</u>	DOB
208003440	Moses (Moshe)	Feder	118-30-0737	2/28/1928
2 207286236	Agi (Agnes)	Filegman	003-36-6579	3/15/1931
3 207286192	Alvin	Lapides	104-22-5850	6/19/1931
√ 20 800125 2	ωla .	Lieber-Schwartz	062-28-437 <u>8</u>	3/15/1923
\$208001896	14808	Salamon	319-82-9298	1/12/193*
Accurint lists Ma	Salamon's 85#	ns 090-30-5929	•	

Please feel free to contact me directly if you need additional information. Thank you!

CC Policy List -	C										
<pre><<poticy for="" list<<="" pending="" policy="" pre="" summary="" u100222<=""></poticy></pre>			Documents Po			Po	licie	5	Activity	Activity	
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Insured Names		Las	Activity of	12-3	1-2007				current as of 01	-22-2008	
	e SSN	Sex									
Insured Nam Primary HANA SALAMON	Birth Da		Issue Age Und			<u>Jnderwriti</u>	ng Class/Rat				
Standard Non-Tobacc											
Coverage											
Death Benefit Option Level										······································	
Coverage Name	ount		Annua	11		Issued	Matur	es/			
Rating					Premiu	m			Expir	es	
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Underwriting											
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Amy Frazer			12-21-20	07				2-13-2007	Cusiritece	0.00	
	Require	ment				Ins			ded Date Re		
			Comm	ent					ocu Date Ne	Celved	
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ATTENDING PHYSICIAN'S						Prin	•	12-21-200			
BROOKLYN NUCLEAR IMAG	GING						,				
BLOOD PROFILE OLDER AGE PROFILE						Prin	агу	12-21-200	7 12-21-200	17	
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HIPAA AUTHORIZATION TO						Prin Prin	•	12-21-200			
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HOME OFFICE URINE SPEC	IMEN					Prim	,	12-21-200			
OLDER AGE PROFILE						7 1111	iai y	12-21-200	7 12-21-200	1	
MISCELLANEOUS						Prin	nary	12-21-200	7 12-21-200	7	
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APPLICATION						Prim	•	12-21-200			
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PLEASE VERIFY SPELLING SIGNED ILLUSTRATION	OF INSURED	SNAME									
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RELEASED BY UNDERWRIT	ING			716		Prim	arv	12-28-2007	12-28-200	7	
AMENDMENT OF APPLICAT	ION					Prim	,	12-28-2007			
CASH						Prim	•	12-28-2007			
ANNUAL PREMIUM \$366,690	0.00						,	.2-20-2007	12-31-200	•	
MISCELLANEOUS						Prim	агу	12-28-2007	12-31-200	7	
CANCELLATION WILL OCCU	IK ON 01/28/2	2008									
Billing											
Billing Method	Frequer	icy Ame	plint		Guideline Single Premium 6,119,178						
Direct Bill (Code I)	Annual	366,6				ne Leve			900,999.84		
Premium Options	Minimu	m Plan				ay Prer			1,138.297.84		
Annual	289,680	.00 366,69	90.00			Exchar	-		0.00		
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Quarterly	72.420	.00 91,61	72.50		p U	Dep	Jail		0.00		

NARRATIVE FOR IFB REFERRAL – HANA SALAMON

AIG developed intelligence that one of our insured's, Hana Salamon, may have recently taken out a life insurance policy for \$8.5M and that there may be certain intentional material misrepresentations on the life policy application concerning the insured's finances. It is further believed that the Broker, Halpert Yitzchok, may be complicit in the misrepresentations on the policy application. This appears to be an Investor Owned Life Insurance (IOLI) investigation wherein an elderly insured is offered an incentive to take out a high dollar life policy, and then, post the 2-year contestability period, the policy will be sold to investors and the death benefit will go to the investors. In the IOLI scenario, the insured takes out the policy with the intent to sell the policy and with that sale, violates the insurable interest statutes.

In this investigation, our insured applied for and was issued a \$8.5M life policy # U10022254 on 12/28/2007. She represented that she has a net worth of \$14M and annual earned income of between \$150K and \$360K, and unearned income of \$470K. Our insured's DOB: is 1.21.1931. She also represented that she is an artist and has her own company called Hana's Gallery.

I will attach copies of the financial representations that were provided to AIG by the insured and broker.

Investigation has disclosed no evidence of any such assets. I have visited this insured at her residence, which is a coop apartment in Brooklyn (not sure if she owns the apartment or not), with a value, where she to own it, of approx. \$215K. My repeated calls to her apartment at 718.851.9250 have not produced any return calls despite my leaving messages. There is a male voice on the answering machine stating, "This is Salamon residence."

I have sent a UPS overnight letter of my request for contact, which I have tracked with a delivery date of 2/8/08. No response elicited.

PINCHAS M. GELLER - ACCOUNTANT FOR HANA SALAMON

Important: The Public Records and commercially available data sources used on reports have errors. Data is sometimes entered poorly, processed incorrectly and is generally not free from defect. This system should not be relied upon as definitively accurate. Before relying on any data this system supplies, it should be independently verified. For Secretary of State documents, the following data is for information purposes only and is not an official record. Certified copies may be obtained from that individual state's Department of State.

Comprehensive Report

Comprehensive Report

Date: 06/27/08

Reference Code: 20080293

Report Legend:

S - Shared Address

D - Deceased

✓ -

Probable Current Address

Subject Information

Name: PINCHAS M GELLER Date of Birth: 10/27/1968

Age: 39

SSN: 073-60-4657 issued in New York between 1/1/1977 and

12/31/1978

View All SSN Sources

AKAS (Names Associated with Subject)

PINCHAS GELLER . Age: 39 SSN: 073-60-xxxx

Indicators
Bankruptcy: No

Property: **No**Corporate Affiliations: **No**

Address Summary

√ 1014 46TH ST APT 3, BROOKLYN NY 11219-2401, KINGS COUNTY (Jul 1999 - Jun 2008)

√ 1227 51ST ST STE B1, BROOKLYN NY 11219-6512, KINGS COUNTY (Feb. 2006 - Apr. 2008)

1280 56TH ST APT 3, BROOKLYN NY 11219-4500, KINGS COUNTY (Jul 1999 - Jan 2007) Phone at address: 718-853-7727 MEISELS JOEL

1280 56TH ST APT 2R, BROOKLYN NY 11219-4500, KINGS COUNTY (Aug 1993 - Jan 2007)

5293 STATE ROUTE 42, SOUTH FALLSBURG NY 12779-5726, SULLIVAN COUNTY (Jul 2005 - Sep 2005)

Phone at address: 845-434-9595 FOGEL MEIR 845-436-5327 BERGER MARILYN

845-434-8258 GRUM HERSCHEL

1280 ST APT 562R, BROOKLYN NY 11201, KINGS COUNTY (Feb 2000)

Others Associated With Subjects SSN:

(DOES NOT usually indicate any type of fraud or deception)
[None Found]

Comprehensive Report Summary: (Click on Link to see detail)

Bankruptcies: None Found Liens and Judgments: None Found UCC Filings.

None Found

Phones Plus

None Found

People at Work:

37 Found

Driver's License

None Found

Address(es) Found

2 Verified and 4 Non-Verified Found

Possible Properties Owned:

None Found

Motor Vehicles Registered:

6 Found

Watercraft:

None Found

FAA Certifications:

None Found

FAA Aircrafts:

None Found

Possible Criminal Records:

None Found

Sexual Offenses:

None Found

Florida Accidents:

None Found

Professional Licenses:

None Found

Voter Registration:

1 Found

Hunting/Fishing Permit:

None Found

Concealed Weapons Permit:

None Found

Possible Associates:

None Found

Bankruptcies:

[None Found]

Liens and Judgments:

[None Found]

UCC Filings:

[None Found]

Phones Plus(s):

[None Found]

People at Work:

Name: PINCHAS GELLER

Title: PRES

SSN: 073-60-xxxx

Company: ACE CONSULTING LPC SRVC

Address: BROOKLYN, NY Phone:

FEIN:

Dates: Aug 30, 2005 - Sep 12, 2007

Confidence: High

Name: PINCHAS GELLER

Title: PROCESS ADDRESS CONTACT

SSN: 073-60-xxxx

Company: C & S REALTY OF NY CORP

Address: 1227 51ST ST # B. BROOKLYN NY 11219-3507

Phone:

FEIN:

Dates: Jun 27, 2005 - Jul 30, 2007

Confidence: High

Name: PINCHAS GELLER

Title: PROCESS ADDRESS CONTACT

SSN: 073-60-xxxx

Company: A - 1 KOSHER SALES CORP

Address: 1227 51ST ST # B. BROOKLYN NY 11219-3507

Phone: FEIN:

Dates: Jun 27, 2005 - Jul 30, 2007

Confidence: High

Name: PINCHAS GELLER

Title: CHAIRMAN OR CHIEF EXECUTIVE OFFICER SSN: 073-60-xxxx

Company: ACE CONSULTING L & P SERVICES INC

Address:

Phone: 718-871-5228

FEIN:

Dates: Jul 18, 2003 - Jul 30, 2007

Confidence: High

Name: PINCHAS GELLER

SSN: 073-60-xxxx

Company: ACE CONSULTING L P SERVICES INC

Address: 1014 46TH ST STE 3, BROOKLYN NY 11219-2401

Phone: 718-853-9612

FEIN:

Dates: Jul 1, 2003 - Jul 1, 2007

Confidence: Medium

Name: PINCHAS GELLER

Title: PRESIDENT SSN: 073-60-xxxx

Company: ACE CONSULTING LPC SRVC

Address: BROOKLYN, NY

Phone: FEIN:

Dates: Jun 30, 2005 Confidence: High

Name: PINCHAS M GELLER

SSN: 073-60-xxxx

Company: JACOB GLICK CPA PC

Address: 1454 42ND ST, BROOKLYN NY 11219-1523

Phone: 718-972-0187

FEIN:

Dates: Sep 1, 2000 - Jun 1, 2001

Confidence: Medium

Name: PINCHAS GELLER

Title: CONTACT

SSN: 073-60-xxxx

Company: SIYATA DISHMAYA CORP

Address: 1014 46TH ST STE 3, BROOKLYN NY 11219-2401

Phone: 718-853-9612

FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT

SSN: 073-60-xxxx

Company: JD LEAD CONSULTANTS INC

Address: 4515 12TH AVE APT B6. BROOKLYN NY 11219-2009

Phone: 718-981-1984

FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: CONTACT SSN: 073-60-xxxx

Company: SUPERIOR DESIGN & PRINTING CORP

Address: 1014 46TH ST STE 3, BROOKLYN NY 11219-2401

Phone: FEIN: Dates: Confidence: High

Connactice. Fight

Name: PINCHAS GELLER

Title: CONTACT SSN: 073-60-xxxx

Company: B & R DISTRIBUTORS CORP

Address: 694 E 7TH ST, BROOKLYN NY 11218-5904

Phone: √ 718-686-0227

FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: CONTACT SSN: 073-60-xxxx

Company: BROOKLYN WOODWORKER SUPPLY INC Address: 90 WATERBURY ST, BROOKLYN NY 11206-1618

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: CONTACT SSN: 073-60-xxxx Company: EITS CORP

Address: 90 WATERBURY ST. BROOKLYN NY 11206-1618

Phone: 718-853-9612

FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: CONTACT SSN: 073-60-xxxx

Company: QUICKAEROBICS INC

Address: 1014 46TH ST, BROOKLYN NY 11219-2401

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: CONTACT SSN: 073-60-xxxx

Company: TRISTATE POWER WASHING CORP Address: 1014 46TH ST, BROOKLYN NY 11219-2401

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: CONTACT SSN: 073-60-xxxx

Company: TRAVEL PROTECTION INC

Address: 1116 44TH ST, BROOKLYN NY 11219-1833

Phone: 718-853-9612

FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx Company: ABARMO PRODUCTS CORP

Address: 1227 51ST ST STE B1. BROOKLYN NY 11219-6512

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: A & H SALES INC

Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: MOBILE MEDIA GROUP INC

Address: 240 52ND ST, BROOKLYN NY 11220-1715

Phone: √718-439-4647

FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: J & J REALTY CONSULTING CORP

Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: WILCAR TOURS INC

Address: 8114 BAXTER AVE APT 5G, ELMHURST NY 11373-1310

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: MAJOR VARIETY CORP

Address: 1710 59TH ST, BROOKLYN NY 11204-2242

Phone: 718-853-9612

FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: LENA DESIGNS INC

Address: 4912 13TH AVE, BROOKLYN NY 11219-3134

Phone: 718-853-9612

FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT

SSN: 073-60-xxxx

Company: MO EQUITIES CORP

Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: AMERICAN FRIENDS OF THE TOLNA ASSOCIATION FOR JEWI

Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: HOME IMPROVEMENT GROUP INC Address: 240 52ND ST, BROOKLYN NY 11220-1715

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx Company: SELECTEL INC

Address: 152 S 9TH ST, BROOKLYN NY 11211-8720

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: TRANSIT MEDIA GROUP INC

Address: 240 52ND ST, BROOKLYN NY 11220-1715

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT SSN: 073-60-xxxx

Company: MEKACH TOV ENTERPRISES INC

Address: 5014 16TH AVE STE 321, BROOKLYN NY 11204-1404

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER CPA

Title: AGENT SSN: 073-60-xxxx Company: RAV TIV LLC

Address: 1312 44TH ST STE 121, BROOKLYN NY 11219-2108

Phone: FEIN: Dates:

Confidence: High

Name: PINCHAS GELLER

Title: AGENT

```
SSN: 073-60-xxxx
Company: SAVE ON TONERS INC
Address: 946 45TH ST. BROOKLYN NY 11219-1701
Phone:
FEIN:
Dates:
Confidence: High
Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: METRO DOORS INC
Address: 965 50TH ST. BROOKLYN NY 11219-3310
Phone:
FEIN:
Dates:
Confidence: High
Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: A-1 PARTY & TENT RENTALS INC
Address: 1111 ROGERS AVE, BROOKLYN NY 11226-7107
Phone: 718-789-9200
FEIN:
Dates:
Confidence: High
Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: STAR DOORS HARDWARE INC
Address: 1275 38TH ST. BROOKLYN NY 11218-1928
Phone:
FEIN:
Dates:
Confidence: High
Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: H C A P INC
Address: 938 51ST ST, BROOKLYN NY 11219-3316
Phone:
FEIN:
Dates:
Confidence: High
Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: PISCHU LI KIRUV KEROVIM INC
Address: 1227 51ST ST STE B1. BROOKLYN NY 11219-6512
Phone:
FEIN:
Dates:
Confidence: High
Name: PINCHAS GELLER CPA
 Title: CONTACT
 SSN: 073-60-xxxx
Company: CHASDEI DAVID INC
Address: 1227 51ST ST STE B1. BROOKLYN NY 11219-6512
Phone:
 FEIN:
 Dates:
 Confidence: High
```

Driver's License Information:

[None Found]

```
Address Summary: View All Address Variation Sources
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√ 1014 46TH ST APT 3. BROOKLYN NY 11219-2401, KINGS COUNTY (Jul 1999 - Jun 2008)

√ 1227 51ST ST STE B1, BROOKLYN NY 11219-6512. KINGS COUNTY (Feb 2006 - Apr 2008)
1280 56TH ST APT 3, BROOKLYN NY 11219-4500, KINGS COUNTY (Jul 1999 - Jan 2007)
1280 56TH ST APT 2R, BROOKLYN NY 11219-4500, KINGS COUNTY (Aug 1993 - Jan 2007)
5293 STATE ROUTE 42, SOUTH FALLSBURG NY 12779-5726, SULLIVAN COUNTY (Jul 2005 - Sep 2005)
1280 ST APT 562R, BROOKLYN NY 11201, KINGS COUNTY (Feb 2000)

Active Address(es): View All Address Variation Sources

√ 1014 46TH ST APT 3, BROOKLYN NY 11219-2401, KINGS COUNTY (Jul 1999 - Jun 2008)

Current Residents at Address:

LEAH Z GELLER PINCHAS M GELLER

1227 51ST ST STE B1, BROOKLYN NY 11219-6512, KINGS COUNTY (Feb 2006 - Apr 2008)

Previous And Non-Verified Address(es): View All Address Variation Sources

1280 56TH ST APT 3, BROOKLYN NY 11219-4500, KINGS COUNTY (Jul 1999 - Jan 2007)

Current Residents at Address:

JOEL MEISELS MEISELS JOEL 718-853-7727

1280 56TH ST APT 2R. BROOKLYN NY 11219-4500, KINGS COUNTY (Aug 1993 - Jan 2007)

5293 STATE ROUTE 42, SOUTH FALLSBURG NY 12779-5726, SULLIVAN COUNTY (Jul 2005 - Sep 2005)

Current Residents at Address:

YECHIEL MYSKI AVRHOM RABINOWITZ BELLA AUSCH DAVID JAROSLAWICZ HERSCHEL GRUM MARTIN REICHMAN

SHANA REICHMAN

YAAKOV AUSCH

JOSHUA MACK JAROSLAWICZ

Current phones listed at this address:

FOGEL MEIR 845-434-9595 BERGER MARILYN 845-436-5327 GRUM HERSCHEL 845-434-8258 845-434-9542

1280 ST APT 562R, BROOKLYN NY 11201, KINGS COUNTY (Feb 2000)

Possible Properties Owned by Subject:

[None Found]

Motor Vehicles Registered To Subject:

Vehicle:

Description: 2006 Toyota SIENNA - Sport Van

VIN: 5TDZA23C16S521398 State Of Origin: NEWYORK Engine: 6 Cylinder 201 Cubic Inch Anti Lock Brakes: 4 wheel standard Air Conditioning: Standard Daytime Running Lights: Not available

Power Steering: Standard Power Brakes: Standard Power Windows: Standard

Security System: Keyless Entry and Al

Roof: None / not available

Price: 23625 Radio: AM/FM CD Front Wheel Drive: Yes Four Wheel Drive: No Tilt Wheel: Standard

Registrant(s)

Record Type: CURRENT

Name: PINCHAS GELLER
Potential SSN **1**: 073-60-xxxx

Address: 1014 46TH ST 3, BROOKLYN NY 11219-2401, KINGS COUNTY

Tag Number: CGZ6899

Earliest Registration Date: 7/27/2006 Latest Registration Date: 3/27/2007 Expiration Date: 3/18/2009 License Plate Type: Private

Vehicle:

Description: 2006 Dodge GRAND CARAVAN - Sport Van

VIN: 2D4GP44L56R854375 State Of Origin: NEWYORK Engine: 6 Cylinder 230 Cubic Inch Anti Lock Brakes: 4 wheel standard

Air Conditioning: Standard
Daytime Running Lights: Optional
Power Steering: Standard
Power Brakes: Standard
Power Windows: Standard

Security System: Sentry Key and Alarm

Roof: None / not available

Price: 27100

Radio: AM/FM Cassette/CD Front Wheel Drive: Yes Four Wheel Drive: No Tilt Wheel: Standard

Registrant(s)

Record Type: CURRENT
Name: PINCHAS GELLER
Potential SSN 1: 073-60-xxxx

POTENTIAL SON TO 1075-00-AAAA Address: 1014 46TH ST 3, BROOKLYN NY 11219-2401, KINGS COUNTY

Tag Number: DRP9590

Earliest Registration Date: 6/7/2006 Latest Registration Date: 6/7/2006 Expiration Date: 6/6/2008 License Plate Type: Private

Vehicle:

Description: Black 1999 Pontiac MONTANA - Extended Sport Van

VIN: 1GMDX03E1XD156860 State Of Origin: NEWYORK Engine: 6 Cylinder 204 Cubic Inch Anti Lock Brakes: 4 wheel standard

Air Conditioning: Standard

Daytime Running Lights: Standard

Power Steering: Standard Power Brakes: Standard Power Windows: Optional Security System: Pass key Roof: None / not available

Price: 23875 Radio: AM/FM Front Wheel Drive: Yes Four Wheel Drive: No Tilt Wheel: Standard

Registrant(s)

Record Type: HISTORICAL Name: PINCHAS GELLER

Potential SSN **1**: 073-60-xxxx Address: 1014 46TH ST 3, BROOKLYN NY 11219-2401, KINGS COUNTY

Tag Number: CGZ6899

Earliest Registration Date: 3/19/2003 Latest Registration Date: 3/17/2005 Expiration Date: 3/18/2007 License Plate Type: Private

Vehicle:

Description: Black 1999 Pontiac MONTANA - Extended Sport Van

VIN: 1GMDX03E1XD156860 State Of Origin: NEWYORK Engine: 6 Cylinder 204 Cubic Inch Anti Lock Brakes: 4 wheel standard

Air Conditioning: Standard Daytime Running Lights: Standard

Power Steering: Standard Power Brakes: Standard Power Windows: Optional Security System: Pass key

Roof: None / not available

Price: 23875 Radio: AM/FM Front Wheel Drive: Yes Four Wheel Drive: No Tilt Wheel: Standard

Owner(s)

Name: PINCHAS GELLER
Potential SSN 1: 073-60-xxxx

Address: 1014 46TH ST 3, BROOKLYN NY 11219-2401, KINGS COUNTY

Title Issue Date: 5/14/2003

Lien Holder(s) None

Vehicle:

Description: 1990 Pontiac BONNEVILLE - Sedan 4 Door

VIN: 1G2HZ54C5L1247687 State Of Origin: NEWYORK Engine: 6 Cylinder 231 Cubic Inch Anti Lock Brakes: 4 wheel optional Air Conditioning: Standard

Daytime Running Lights: Not available

Power Steering: Standard Power Brakes: Standard Power Windows: Standard Security System: None Roof: None / not available Price: 19144

Radio: AM/FM
Front Wheel Drive: Yes
Four Wheel Drive: No
Tilt Wheel: Standard

Registrant(s)

Record Type: HISTORICAL
Name: PINCHAS GELLER
Potential SSN 1: 073-60-xxxx

Address: 1280 56TH ST APT 3, BROOKLYN NY 11219-4500, KINGS COUNTY

Tag Number: D917DV

Earliest Registration Date: 7/1/1999 Latest Registration Date: 7/1/1999 Expiration Date: 7/12/2001 License Plate Type: Private

Vehicle:

Description: 1990 Pontiac BONNEVILLE - Sedan 4 Door

VIN: 1G2HZ54C5L1247687 State Of Origin: NEWYORK Engine: 6 Cylinder 231 Cubic Inch Anti Lock Brakes: 4 wheel optional

Air Conditioning: Standard

Daytime Running Lights: Not available

Power Steering: Standard Power Brakes: Standard Power Windows: Standard Security System: None Roof: None / not available

Price: 19144 Radio: AM/FM Front Wheel Drive: Yes Four Wheel Drive: No Tilt Wheel: Standard

Owner(s)

Name: PINCHAS GELLER

Potential SSN 0: 073-60-xxxx

Address: 1280 56TH ST APT 2R, BROOKLYN NY 11219-4500, KINGS COUNTY

Title Issue Date: 6/29/1999

Lien Holder(s)

None

Watercraft:

[None Found]

FAA Certifications:

[None Found]

FAA Aircrafts:

[None Found]

Possible Criminal Records:

[None Found]

Sexual Offenses:

[None Found]

Florida Accidents:

[None Found]

Professional License(s):

[None Found]

Voter Registration:

Name: PINCHAS M GELLER Address: 1014 46TH ST, BROOKLYN NY 11219-2401

DOB: 10/27/1968 Gender: Male

Last Vote Date: 11/7/2006 Political Party: DEMOCRAT State of Registration: New York

Status: ACTIVE

Hunting/Fishing Permit:

[None Found]

Concealed Weapons Permit:

[None Found]

Possible Associates:

[None Found]

Source Information:

23 Source Document(s) All Sources 8 Source Document(s) Motor Vehicle Registrations 1 Source Document(s) Person Locator 1 1 Source Document(s) Voter Registrations 3 Source Document(s) Phone 4 Source Document(s) Historical Person Locator 4 Source Document(s) Person Locator 2 2 Source Document(s) Person Locator 4